Maternal and Child Health Services
Title V Block Grant

State Narrative for North Dakota

Application for 2013
Annual Report for 2011

Document Generation Date: Monday, September 24, 2012

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section. IA - Letter of Transmittal

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

/2013/Signed assurances and certifications will be maintained on file in the North Dakota Department of Health, Division of Family Health. As required in Section 502(a)(3), funds will only be used for the purposes specified. As required in Section 505(a)(5)(B), funds will only be used to carry out the purposes of this title.//2013//

An attachment is included in this section.
An attachment is included in this section. IC - Assurances and Certifications

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2012; expires January 31, 2015.

E. Public Input

In May 2009, a five-year needs assessment "kick-off" meeting was held for state Title V staff, Department of Health epidemiology partners and the executive director for Family Voices ND, Inc. Agenda items included:

* Title V Overview and History (the MCH History Time Line was used to develop content)
* Title V Needs Assessment Mission and Goals
* Title V Needs Assessment Process and Timelines

As a result of this meeting, a core group of Title V staff were selected to lead the five-year needs assessment process.

In August 2009, a Title V/MCH Needs Assessment Survey was sent out to a variety of stakeholders to gather input on the perceived needs for the three target population groups: pregnant women, mothers and infants to age one; children and adolescents ages 1 to 24; and children and youth with special health care needs (CYSHCN). Each Title V core workgroup member provided input to identify and select stakeholders to ensure a broad representation of survey response. A total of 502 responses were received from a variety of affiliations including state agencies (15%), local public health (13.8%), family members (10.4%), county social services (7.9%), health care providers (7.9%), advocacy organizations (7.5%), schools (6.9%), community-based organizations (5.1%), disability services (4.7%), early childhood services (4.7%), universities/colleges (4.1%), clinics (3.1%), hospitals (2.6%), law enforcement (1.8%), legislators (1.2%), judicial (1.0 %), health plan/insurers (0.8%), tribal entities (0.8%), childcare/daycare providers (0.4%), and regulatory entities (0.4%). As is evident by the percentage response, key stakeholders that Title V engages with on a consistent basis had good response rates. Ongoing challenges engaging legislators, tribal entities and others were seen

with survey responses. Results of the survey were shared back to stakeholders via email.

In October and November 2009, nine focus groups were conducted in urban and rural areas of ND targeting youth ages 14-17 (54 participants); young adults ages 18-24 (43 participants); and parents of children with special health care needs (7 participants). The focus group participants were recruited through a variety of means including phone calls to family organizations; letters to high school and university counselors; emails and letters to consumer groups and Head Start centers; and through public announcements.

Qualitative data was gathered at each focus group to assess general behaviors of youth and young adults, identify patterns and themes and get suggestions from parents of children with special health care needs on improving existing services or creating new ones. The ND Center for Persons with Disabilities, a University Center of Excellence at Minot State University, was contracted with to conduct the focus groups.

The Title V core workgroup spent December 2009 and January 2010 examining and analyzing the results of the stakeholder survey and the focus groups, as well as numerous other pertinent data sources, to develop a data presentation. On February 2, 2010, a planning retreat with 75 key stakeholders was held. Needs Assessment data was presented, and with the help of a facilitator, priority needs were identified. There was good representation and attendance from state agencies and county social services. Fewer representatives were in attendance from local public health, advocacy and community-based organizations. Only one legislator and one tribal representative were present. Results of the planning retreat were shared with partners via email.

In February and March 2010, the core Title V planning staff refined the identified priorities, developed performance measures and discussed intervention strategies and partner opportunities. The needs assessment process and the resulting ten priorities/performance measures have been shared with various groups.

The ND Department of Health's website has been used to share information related to the needs assessment with the general public. Data presentations and reports from the focus group study and retreat planning process are available on line. An electronic survey was recently added to the Children's Special Health Services (CSHS) homepage to elicit feedback from consumers.

Besides the needs assessment process, public/stakeholder input is gathered on a regular basis throughout the year. The Title V and CYSHCN directors provide updates on the MCH grant and grant application process at the local public health administrator, director of nurse, and clinic coordinator meetings. Information regarding to the budget, pyramid level of services and MCH activities related to the federal and state performance measures are discussed.

Annual updates on the MCH application activities are provided to the CSHS Advisory Councils and Community Health Section Advisory Committee. All of these groups have a broad range of representatives from throughout the state who provide input in directing public health efforts. Members of the CSHS Family Advisory Council also participated in the ranking to assess family participation in the State children with special health care needs program.

Bi-monthly meetings are held with all Title V staff to provide Title V updates, to encourage collaboration around various program activities and to facilitate the grant writing process. Title V staff complete specific parts of the grant application such as the annual report and plan relating to the federal and state performance measures and the narrative reporting for the health system capacity and health status indicators.

On July 2, 2010, a news release was sent to most major media outlets in the state. The release provided information about the new priority needs that had been identified for the MCH population through the statewide needs assessment and announced that the Title V application was available for public comment on July 7, 2010. Historically, few requests are received each year

for the full Block Grant application.

/2012/ On July 1, 2011, a news release was sent to most major media outlets in the state. The release provided information about the 2011-2015 priority needs that had been identified for the MCH population through the statewide needs assessment and announced that the Title V application was available for public comment on July 8, 2011. Historically, few requests received each year for the Block Grant application are minimal.

The ND Five Year Needs Assessment (2011-2015) document has been placed on the ND Department of Health's website. Additional partners that have been asked to include a link to the document on their website include the ND State Data Center, Family Voices of ND and the ND Center for Rural Health.

All other efforts to inform and receive feedback from stakeholders continue such as providing updates at various council and committee meetings and posting information to the Department of Health's website. As a result of this sharing, representatives of the Family Advisory Council plan on participating in ND's grant review in August 2011.//2012//

/2013/ On July 10, 2012 a news release was sent to most major media outlets in the state. The release provided information about the 2011-2015 priority needs that had been identified for the MCH population through the statewide needs assessment and announced that the Title V application was available for public comment. Historically, requests received each year for the Block Grant application have been minimal.

Printed copies of an Executive Summary of ND's Five-Year Needs Assessment were distributed to various stakeholders. Printed fact sheets that were developed to address each of the state's ten priority needs have also been disseminated. Both of these resources are available on the ND Department of Health's website as well as those of various Title V partners such as Family Voices of ND and ND Kids Count. This year, special effort was made to inform local public health about the various needs assessment documents. Feedback on their usefulness was solicited.

Other efforts to inform and receive feedback from various stakeholders continue. Council and committee meetings that are held throughout the year are an important avenue for feedback. For example, members of the CSHS Family Advisory Council were able to help rank family participation in the State Children with Special Health Care Needs Program and provided suggestions for activities that could be included in the state plan as it was developed. Representatives of the Family Advisory Council also volunteered to participate in ND's grant review in August 2012.

In addition to posting relevant Title V-related information to the Department of Health's website, a new Social Media Policy has been drafted for the North Dakota Department of Health. As a result, the Public Information Officer will be establishing a Department of Health Facebook page and Twitter account that can be used for overall department messages. With approval, programs may also develop their own accounts when targeted messaging is needed for specific audiences. Title V programs plan to participate on the Department of Health's Facebook page or develop their own.//2013//

II. Needs Assessment

In application year 2013, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

From January 2009 through July 2010, the Five-Year Needs Assessment for the Maternal and Child Health Services Title V Block Grant Program was completed. A comprehensive assessment and planning process resulted in the identification of the following 10 state priority needs:

• Form and strengthen partnerships with families, American Indians and underrepresented populations.

• Form and strengthen a comprehensive system of age appropriate screening, assessment and treatment for the MCH population.

• Support quality healthcare through medical homes.

• Increase participation in and utilization of family support services and parent education programs.

• Increase access to available, appropriate and quality health care for the MCH population.

• Promote optimal mental health and social-emotional development of the MCH population.

• Increase the number of childcare health consultants and school nurses who provide nursing health services to licensed childcare providers and schools.

• Reduce violent behavior committed by or against children, youth and women.

• Reduce the rate of deaths resulting from intentional and unintentional injuries among children and adolescents.

• Promote healthy eating and physical activity within the MCH population.

Changes in the priorities in the four interim years between the State MCH needs assessment was a result of increased stakeholder participation, enhanced state level data analysis, new methods for priority setting and emerging Federal and State initiatives.

Because a systems approach was used to develop the new priorities, several of the 2006-2010 priorities were integrated within the 2011-2015 priorities. The priorities that represent significant changes from the prior needs assessment include: partnerships with families, American Indians and underrepresented populations; promotion of mental health and social-emotional development; increased childcare health consultants and school nurses; and the reduction of violent behaviors.

The needs assessment demonstrates that North Dakota is very effective at delivering many of the essential health services for the three main audiences served by Title V, including a) pregnant women, mothers, and infants, b) children and adolescents, and c) children with special health care needs (CSHCN).

In general, state MCH program capacity has remained relatively unchanged. However, MCH epidemiology and oral health capacity has increased slightly.

One of the health system concerns is the changing demographic profile of the state, especially with a growing elderly and rural population. This clearly highlights the emerging challenges North Dakota faces with regard to ensuring access to adequate health care for all residents. In addition, the concentrated nature of North Dakota's population has created significant challenges with regard to its ability to supply sufficient numbers of health care professionals in sparsely populated areas.

North Dakota is committed to an ongoing needs assessment process that will improve outcomes and strengthen partnerships on behalf of the MCH population.

/2012/ A comprehensive five-year needs assessment and planning process was completed for the FY 2011 application. Since that time, there have been no major changes in state priorities for the Maternal and Child Health (MCH) population.

MCH program and system capacity has also remained relatively unchanged. However, any significant decreases in federal MCH Block Grant funding have the potential to impact service delivery. Increased demands in response to energy development and North Dakota's flood situation could also strain state and local public health programs and systems for the MCH population.

Title V needs assessment activities are ongoing. New publications that have been made available since the five-year assessment was conducted follow:

• 2010 Snapshot of ND's Health Care Workforce http://ruralhealth.und.edu/publications/22
• State Rural Health Plan http://ruralhealth.und.edu/publications/22
• ND Strategic Planning Framework State Incentive Grant Needs Assessment http://www.nd.gov/dhs/services/mentalhealth/prevention/pdf/needsassessment.pdf

As a requirement for the Maternal, Infant and Early Childhood Home Visiting Program grant, an additional needs assessment was conducted May through August 2010 that identified priority ND communities in greatest need of a home visiting program. Although ND did not receive approval to implement the Home Visiting Program, the needs assessment document will be an important tool to support future efforts for the MCH population (i.e., Race to the Top -- Early Learning Challenge Grant). The Maternal, Infant and Early Childhood Home Visiting Program Needs Assessment can be viewed at http://www.ndhealth.gov/familyhealth/Publications/ND_Needs_Assessment_to_HRSA.pdf

The SSDI coordinator, MCH epidemiologist and several Title V staff participate on the Department of Health's (DoH) Healthy People 2010/2020 Committee. The Committee's role is to select state objectives by soliciting program input and coordinating with the DoH's strategic plan. In addition, committee members provide guidance and recommendations on data reporting. Many programs within the DoH utilize Healthy People objectives for tracking program specific indicators, program evaluation, demonstration of need within the state and demonstration of trends within program areas. The Healthy People 2010 North Dakota Final Report can be viewed at www.ndhealth.gov/HealthyPeople2010

During the last year, the comprehensive five-year needs assessment was made into a stand-alone publication with the help of a professional graphic designer. This work effort was funded through the State Systems Development Initiative (SSDI). The publication titled North Dakota Five-Year Needs Assessment (2011-2015) for the Maternal and Child Health Services Title V Block Grant Program is available at the following link on the North Dakota Department of Health's website at: http://www.ndhealth.gov/familyhealth/. This publication is also available on the Family Voices, State Data Center and Center for Rural Health websites. Recently, an executive summary of the needs assessment document was professionally drafted, which will soon be available in print and electronic formats.

The major activity undertaken to operationalize the five-year needs assessment includes the development of fact sheets for each of the state's new performance measures. SSDI funding is supporting the development of these fact sheets with the assistance of staff from the North Dakota State Data Center. Title V staff are also lending their programmatic expertise in determining content that will be included. These fact sheets will be completed by late fall 2011. All of the aforementioned publications will help Title V staff in sharing needs assessment findings which can be used to promote collaborative work activities to improve the health of the maternal and child health population in North Dakota.//2012//

/2013/ A comprehensive five-year needs assessment and planning process was completed for the FY 2011 application. Since that time, there have been no major changes in state priorities for the Maternal and Child Health (MCH) population.

MCH program and system capacity has also remained relatively unchanged. However, any significant decreases in federal MCH Block Grant funding have the potential to impact service delivery. Increased demands in response to energy development and North Dakota's flood situation could also strain state and local public health programs and systems for the MCH population.

Title V needs assessment activities are ongoing. Resources have been developed that helped Title V staff in sharing needs assessment findings that were used to promote collaborative work activities to improve the health of the maternal and child health population in North Dakota.

During the last year, an executive summary of the comprehensive five-year needs assessment and state performance measure facts sheets were finalized and distributed. The North Dakota Five-Year Needs Assessment (2011-2015) for the Maternal and Child Health Services Title V Block Grant Program Executive Summary and ten state performance measure facts sheets that were funded through the State Systems Development Initiative (SSDI) are available at the following link on the North Dakota Department of Health's website at: http://www.ndhealth.gov/familyhealth/

New publications that became available in the last year follow:

CSHCN

• Disability-Related health Disparities Among North Dakota Adults and Adolescents, 2012: www.ndcpd.org/health
• 2009//10 National Survey of Children with Special Health Care Needs: www.childhealthdata.org
• In Search of an Answer -- Listening and Responding: North Dakota Survey of Agencies Serving Children and Youth with Special Health Care Needs: www.fvnd.org

Child Health

• North Dakota Head Start State Collaboration Office Needs Assessment 2011-2012 Survey Results: www.nd.gov/dhs/services/childfamily/headstart/docs/hssco-needs-assessment11-12final/pdf
• 2007 National Survey of Children's Health Disparities Snapshot for ND - Race/Ethnicity: www.childhealthdata.org
• North Dakota Kids Count: www.ndsu.edu/sdc/publications/popbulletins.htm#popdem

Mental Health and Substance Abuse

• ND Strategic Planning Framework State Incentive Grant:

www.nd.gov/dhs/services/mentalhealth/prevention/pdf/needsassessment.pdf - 34k - 2011-05-16

Capacity

• First Biennial Report on Health Issues for the State of North Dakota 2011: www.med.und.edu/community/files/docs/first-biennial-report.pdf - 2011-07-18
• Health Workforce Factsheets: http://ruralhealth.und.edu/topics/workforce/factsheets.php

Energy Impact

• Energy Impact in North Dakota 2011: www.ag.ndsu.edu.ccv/documents/energy-impacts

Rural Health

• Rural Health Factsheets: http://ruralhealth.und.edu/publications/2
• Primary Issues Impacting Rural Health in North Dakota and Contributing Factors: http://ruralhealth.und.edu//2013//

III. State Overview

A. Overview

North Dakota (ND) is a beautiful agricultural state located in the geographic center of the United States between Montana and Minnesota, adjacent to the Canadian provinces of Saskatchewan and Manitoba. It encompasses significant landmass (68,976 square miles) divided into 53 counties and spread over four distinct regions; the southwestern Great Plains (badlands), northwest Missouri Coteau (plateau), central Glaciated Plains, and eastern border Red River Valley. ND's health status is confronted by a variety of challenges including the unique geography and climate, demographics, and socioeconomic factors of the state.

ND experiences temperature and precipitation fluctuations and bears relentless wind. Average annual temperatures range between 0 degrees in winter and 68 degrees in the summer, with intermittent temperature extremes ranging from -60 degrees to 121 degrees. Furthermore, ND is prone to annual flooding, tornados (22 reported annually), wind storms and hail storms. Flooding of the Red River and Missouri River is caused by the annual spring thaw of accumulated winter snow (35 inches annually) and significant annual rainfall (18 inches). In each of the last two years, severe flooding caused damage to the central and eastern regions of the state. Governor John Hoeven declared these events statewide natural disasters. In response to this, the ND Department of Health (DoH) activated the Department Operation Center (DOC) which coordinates activities between state and local entities. The state Title V director is a member of the DOC team. In addition, the DoH established a centralized public safety/awareness campaign and Title V staff members assisted with evacuation of healthcare facilities.
/2012/ Flooding continues to be a major challenge throughout the state, especially along the Missouri River where 500-year flood levels are predicted. Many DoH staff have been personally impacted by the flood this year. In addition, numerous DoH staff members have spent countless hours helping with flood efforts (i.e., sandbagging). The DoH DOC plays a critical role in statewide response efforts. A DoH website containing flood cleanup health and safety information can be viewed at http://www.ndhealth.gov/flood/ //2012//
/2013/ According to the Federal Emergency Management Agency (FEMA), public health and safety efforts following the 2011 ND flooding cost more than $60 million dollars to FEMA and nearly $7 million dollars to the ND Department of Emergency Services. Additionally, FEMA paid just under $60 million dollars for resident claims.//2013//

Despite these natural hazards, North Dakotans thrive in the competitive agricultural/ranching, coal mining and oil drilling industries. Fertile ND croplands sustain approximately 27,000 farmers and ranchers, yielding significant harvest (fourth most cropland harvested in nation) and cattle production (tenth highest production in nation). Currently, ND ranks fourth in United States oil production. Most of ND's precipitation arrives during the summer hurricane season as prevailing winds carry evaporated surface waters from the Gulf of Mexico. Hence, large scale surface oil limiting water evaporation in the Gulf may be of significant concern.
/2013/ Energy development has transformed the state of ND. Currently, oil production in the state is second highest in the nation behind the state of Texas. The number of oil workers in the state has increased by over six times from 2007 (~2,000) through 2010 (~12,750). Furthermore, the state population has continuously increased within western ND and the largest state counties. According to a 2011 Energy Impacts report, western ND has been impacted greatly from energy development. The top eight challenges include housing, roads/traffic, workforce, law enforcement/emergency response, infrastructure, lifestyle changes, environmental concerns, and schools. Opportunities and positive benefits were also addressed. The top three included economic benefits to existing businesses, better paying jobs, and more job opportunities for workers.//2013//

ND has a uniquely low population (646,844), ranking as second least populated state in the nation, with a state population density of 9.3 persons per square mile. White/Caucasians comprise a solid majority (91%) of the total ND population. Minority populations have grown

considerably over the last several years. American Indian/Alaskan Native persons calculate to nearly six percent of the total population, Hispanic or Latino origin persons equal two percent and Black/African American persons equal approximately one percent of the total ND population. /2012/ The 2010 U.S. Decennial Census indicates that the ND population has increased by 4.7 percent since 2000, reaching 672,590 in 2010, and having a state population density of 9.7 persons per square mile. Although racial minorities continue to represent a small proportion of the state's total population (1 in 10), the racial minority population has grown by 37 percent over the past decade. White/Caucasians comprise a solid majority (90%) of the total ND population. American Indian/Alaska Native persons calculate to 5.4 percent of the total population, Black/African American persons equal 1.2 percent of the total population, Asian persons equal 1.0 percent, and Hispanic or Latino origin persons (of any race) equal 2.0 percent. Nearly 2.0 percent (1.8) of the population reported to be of two or more races. The percentage of Native Hawaiian and other Pacific Islander persons in the state was small, CDC-labeled as "greater than zero, but less than half unit". Factors involved in the population increase include net in-migration and natural change (more births than deaths). Much of the in-migration is a result of the population growth in the western part of the state as a result of heightened energy development activity.//2012//
/2013/ According to the United States Department of Agriculture (USDA) urban/rural definitions, the 2010 ND population distribution is nearly equal between rural (51.6%) and urban (48.4%) counties.//2013//

The American Indian ethnic group (6% of total ND population) may be found either on one of the four ND reservations, on the Indian Service Center, or scattered across the state. Several disparities facing the American Indian population include poverty, obesity, teen pregnancy, STD rates, and poor oral health. In American Indian reservation areas, one in four residents lives in poverty. Teenage births from American Indian mothers are approximately eight times higher than other ND teenagers. 2008 surveys indicated that 25 percent of infants born to American Indian mothers have not received adequate care during pregnancy.
/2013/ 2010 U.S. Decennial Census indicates that the ND American Indian ethnic group makes up only 5.4 percent of the total population. The 2008 rate of SIDS among American Indian infants (2.0 per 1,000) was much higher than white infants (0.3 per 1,000). In this same time period, nearly three in five American Indian children (61%) birth to age four were impoverished.//2013//

American Indians living on the reservation have access to healthcare services through the Indian Health Service (IHS) as well as Tribal Health Services (THS). Communication has ensued between the American Indian tribes, the DoH and Department of Human Services (DHS) to collaborate in addressing poverty and health concerns. American Indians residing outside the reservation/within an urbanized city have limited access to tribal healthcare services and are less likely to be able to afford unsubsidized care. The recent increase of minority and New American populations creates implications for unique approaches to healthcare access and services. From 1997-2009, 4,481 New Americans arrived in ND from Europe, the Middle East, and Africa. Most New Americans report to have come to ND for employment opportunities and to improve the quality of life for their family. An average of 590 foreign nationals is granted permanent legal status each year. The Cass County public school system reports that several independent languages are frequently spoken within New American population homes.
/2012/ The American Community Survey for CY 2009 indicates that 2,209 people moved to ND from abroad. Of those 2,209 people, 1,017 were not U.S. citizens (46%). The New American Services for ND identified that in CY 2009, 507 people classified as refugees moved into ND.//2012//
/2013/ In CY 2010, many people moved to ND from abroad (3,612), according to the American Community Survey Estimates. Of the 3,612 people, 1,689 were not U.S. citizens (47%). The New American Services for ND identified that in CY 2010, 485 people classified as refugees moved into ND. Six percent of all ND children 18 years and under were estimated to be foreign born or at least reside with one foreign-born parent.//2013//

Specific ND population age distribution indicates that the male/female ratio is approximately equal. Age distribution data from 2008 estimates that approximately 6.5 percent of the ND population is less than five years of age, 22.3 percent is under 18 years of age and nearly 15 percent of the population is elderly (65 years of age or older). The 10-year population estimate for elderly North Dakotans is 23 percent.
/2012/ Age distribution data from 2009 estimates that approximately 6.7 percent of the ND population is less than five years of age, 22.3 percent is under 18 years of age and nearly 15 percent of the population is elderly (65 years of age or older). Population projections indicate that the elderly proportion of the state's population will reach 23 percent by 2020.//2012//
/2013/ Age distribution data from the 2010 U.S. Decennial Census indicates that approximately 6.6 percent of the ND population is less than five years of age, 22.3 percent is under 18 years of age and 14.5 percent of the population is elderly (65 years of age or older), consistent with previous survey estimates.//2013//

Presently, a majority (63%) of ND residents live within eight urban counties. However, the majority of ND counties possess a population base below 5,000 residents, including 36 counties considered "frontier"; defined as having a population density of six or fewer residents per square mile. As indicated by the census data in Figure 1 (attached), ND reached its highest population (680,845 residents) in 1930. At that time, approximately 85 percent of the population lived in a rural environment such as "on a farm, in the countryside, or in a community with less than 2,500 people." Urbanization followed throughout the 1950s and into the 1960s, depopulating many smaller ND towns. This trend continued into the 1970s and through the 1990s, when the majority of North Dakotans living in an urban environment exceeded those living in a rural environment. Consequently, there were also fewer children born in rural ND. From 1990 to 2000, the ND population grew by just 0.5 percent: the smallest relative growth of any state at that time. Early within the new millennium, the population actually declined. In 2008, only 31 percent of young adults ages 20-34 lived in rural ND counties.
/2013/ The 2010 U.S. Decennial Census indicates that a majority of ND residents (68%) reside within either a metropolitan or micropolitan area (the eight most populated counties in the state).//2013//

Figure 1: North Dakota Population by Rural and Urban Status: 1870 to 2009 (see attachment). Source: U.S. Census Bureau; Decennial Censuses, Vintage 2009 Population Estimates, and the 2006-2008 American Community Survey 3-Year Estimates. The 2006-2008 ACS urban and rural population distributions were applied to the vintage 2009 total population estimates to calculate the 2009 distributions.

This trend of urbanization is not uniformly distributed across all age groups. It is primarily associated with "working age" people (20-50 years old) who move from rural areas to urban population centers or out of state to secure employment. The net effect is a continued reduction in births and a general aging of the 21 percent of the population that remains in these 36 frontier counties.

Six tertiary-care hospitals based in the most urban ND communities provide advanced healthcare services and network with 39 hospitals to provide access to healthcare in rural areas. Also, ND maintains 305 strategically located ambulatory care centers and federally designated Rural Health Clinics to provide both primary and specialty healthcare throughout the state. However, most rural hospitals/health clinics have not implemented electronic medical record systems (EMR), thereby slowing communication between other health agencies and delaying reporting of performance data. Furthermore, travel for healthcare services often entails significant amounts of time and effort for rural residents, straining already restrictive time schedules and financial resources. In addition, ND lacks regular statewide mass transportation systems. Hence, for access to competitive healthcare services and goods, the automobile is the primary means of transportation, although costs for maintenance/gasoline can be a tremendous burden. To address these limitations to healthcare, five federally-funded Community Health Center Organizations provide networked care through 11 medical clinics and three dental clinics throughout the state.

/2013/ Sanford Health is expanding its presence within the Fargo/Moorhead community with a new Moorhead campus. Sanford Health is an integrated health system headquartered in Fargo, ND and Sioux Falls, SD. It is now the largest, rural, not-for-profit health care system in the nation with locations in 112 communities in seven states. Sanford Health includes 34 hospitals, 116 clinic locations and more than 1,000 physicians in 70 specialty areas of medicine. With more than 20,000 employees, Sanford Health is the largest employer in North and South Dakota.//2013//

Considering that agriculture comprises a significant portion of the state gross product, it is understandable that there may be significant fluctuations in the per capita income from year to year. The boom/bust phenomenon in the energy industry has had a significant impact on the economic status of North Dakotans in the western part of the state; the ability of individuals to afford healthcare services has increased, although the essentiality of more basic needs (i.e.; shelter) have become the priority. Shelter within the western regions of the state thriving in oil collection/production is extremely limited, causing Governor Hoeven to utilize state funds to provide temporary housing for the oil workers.

Although ND maintains one of the highest employment rates in the nation, nearly 12 percent of North Dakotans live in poverty (~71,000), equating to approximately the entire population of the ND capital city, Bismarck. The 2008 ND median household income was $45,996 and per capita income was $17,769 compared with the national median $52,209 and per capita $21,587. All but one ND County has per capita income lower than the national average and nearly all of the frontier counties have per capita incomes lower than the state average.
/2012/ The 2009 ND median household income was $47,898 and per capita income was $24,978 compared with the national median income ($50,221) and per capita income ($27,041).//2012//
/2013/ An estimated 12.3 percent of ND residents (~83,000) live in poverty, according to the American Community Survey for 2006-2010. This survey estimates that the ND median household income was $46,781 and per capita money income in past 12 months was $25,803 compared with the national median income ($51,914) and per capita income ($27,334).//2013//

From 1960-2008, the number of single parents with children under 18 increased by over 400 percent. In 2008, one in three pregnancies were to unwed mothers (2,990) and nearly two-thirds of children 0 to four years of age living with a single mother were living in poverty. Sixty percent of all children without health insurance were from single parent families. Additionally, seventy-five percent of children ages 0 to four living with single mothers in rural areas were in poverty. Nearly one-fifth of pregnancies (19%) ended in induced terminations for teenagers 19 and younger.
/2013/ In 2010, over one in three pregnancies were to unwed mothers (37%). However, ND ranked second lowest (25%) in the nation in the percentage of children under age 18 who live with a single parent. The 2010 pregnancy rate for ND teenagers is 34.88 per 1,000, much higher than the ND resident pregnancy rate of 14.91 per 1,000. An estimated one-fifth of ND children (21%) ages 0 through 4 live in poverty. Also, the 2010 ND divorce rate (3.07 per 1,000 residents) is the highest since 2004.//2013//

There is an increasing prevalence of preterm births and very low weight multiple births within the ND population. In 2008, over one-fourth (27.26%) of births were C-Section. In 2009, 122 successful births had required fertility treatment. A 2002 ND PRAMS study indicated that pregnant women engage in risky behaviors that can cause fetal complications. Approximately twenty percent of women indicated that they had not received adequate prenatal care during their first trimester of pregnancy. Twelve percent reported that the reason they could not get prenatal care as early as desired was that they did not have enough money or insurance to pay for the care. More than one-third (37%) reported to have binge drank alcohol and over one-fourth (26%) smoked within three months prior to pregnancy. Also, four percent drank alcohol and almost one fourth (16%) smoked during the last three months of pregnancy.
/2013/ In 2011, over one-fourth (28.8%) of births were C-Section.//2013//

The Health Resources and Services Administration (HRSA) identifies that many North Dakotans currently live in rural areas having a shortage of primary care professionals (22%) and mental health services (33%). Healthcare providers may not be inclined to practice far from regional tertiary-care hospitals, in rural areas with a large elderly population, and providing care to residents living in poverty and lacking health insurance. ND is at risk of losing several healthcare providers to retirement within the next 10 years and healthcare vacancies indicate the present need for 271 medical and mental health professionals throughout the state.

While most North Dakotans have some form of health insurance, many residents are without coverage. In 2006, the proportion of uninsured among ND residents was eight percent for children ages one to 18, 19 percent for adults ages 18 to 39, 12 percent for adults ages 40 to 49, and 9 percent for adults ages 50 to 64. Nearly all ND residents ages 65 and over are covered by care coverage, which is 12 percent of all people statewide. To complicate this, many adult North Dakotans continue to engage in unhealthy behaviors. A large majority (64.5%) are considered overweight or obese, over one-fifth (21%) of the population smokes and nearly one-fourth (23.2%) binge drinks alcohol.
/2012/ The Community Population Survey three-year average from 2007 through 2009 estimated that the proportion of uninsured among ND residents ages 1 through 17 was 6.9 percent, ages 18 through 39 was 18.4 percent, ages 40 through 49 was 12.3 percent, and ages 50 through 64 was 9.5 percent. Nearly all residents ages 65 and older were covered by some form of health insurance. Overall, 12.4 percent of all residents were estimated to be uninsured.//2012//
/2013/ The percentage of all uninsured ND residents has increased to 15.8 percent (based on 2009 through 2011 Current Population Survey estimates). The proportion of uninsured among residents ages 1 through 17 was 9.6 percent, ages 18 through 39 was 26.2 percent, ages 40 through 49 was 18.9 percent, and ages 50 through 64 was 14.3 percent. Nearly all residents ages 65 and older were covered by some form of health insurance (98.2%).//2013//

ND children 21 years of age or younger that have disabilities, chronic illnesses, and/or educational/behavioral problems requiring additional health services may be classified under the ND special needs population and receive special healthcare services. Approximately one-sixth (15%) of ND residents age five and older have a disability. Half (50.1%) of these residents self report to be in only "fair" or "poor" health. ND BRFSS data from 2001-2007 suggested that older females of American Indian descent who were less educated and who had held a lower income were more likely to be considered "disabled". In 2006, ND provided more coordinated and comprehensive care services to special needs children compared to the national average. A 2005 study indicated that a majority (92%) of families of children with special needs agreed that the ND services were easy to utilize. However, in 2006, only 60 percent of families with children with special health care needs ages zero through 17 reported to have adequate funding to pay for private healthcare, indicating the dynamic need for these services.
/2012/ Family Voices of ND supported a project to help identify the experiences of families that had children and youth with special health care needs (CYSHCN) as they searched for resources, information, financial support, emotional support and access to services. Organizations and agencies across ND that serve CYSHCN were surveyed by telephone and asked to respond to a family scenario. Responses were rated for both responsiveness and respectfulness based on a subjective scale and interpretation from the vantage point of a parent of a CYSHCN. Results were then shared with agency directors and partners. Over 200 programs were called with an average rating of 2.2 on a five point scale. Full results of the survey and recommendations to improve the system of care for CYSHCN's and their families are available in a report titled In Search of an Answer -- Listening and Responding: North Dakota Survey of Agencies Serving Children and Youth with Special Health Care Needs, which can be viewed at: http://www.fvnd.org/publications_2 //2012//

ND has several health care resources for those needing coverage:

Medicaid: ND Medicaid provides comprehensive medical, dental and vision coverage for ND

children and adults. Eligibility requirements are at 133 percent of the Federal poverty level for pregnant women and children to age six. Eligibility requirements are at 100 percent of the Federal poverty level for children ages 6-19. ND Medicaid has established a continuous eligibility policy which maintains coverage following enrollment. Medicaid is a safety net for many families that have kids with disabilities. It also has a waiver program which offers assistance to medically fragile children between the ages 3 and 18. Medicaid also offers programs designed to provide coverage for the blind, disabled, or elderly and programs for Medicaid beneficiaries that would like to work and remain enrolled in the program.
/2013/ From February 2010 through January 2011, an average of 38,044 children were enrolled in Medicaid. From February 2011 through January 2012, an average of 38,849 children were enrolled in Medicaid, an increase of 805 from the previous year.//2013//

Healthy Steps (SCHIPS): Healthy Steps, ND's State Children's Health Insurance Plan, provides premium-free, comprehensive health, dental, and vision coverage to uninsured children up to 19 years old who do not qualify for Medicaid. Eligibility requirements are at 160% of the Federal poverty level. Modest co-payments apply for certain services, which are waived for American Indian children.
/2013/ From February 2010 through January 2011, an average of 3,586 Healthy Steps premiums were paid. From February 2011 through January 2012, an average of 3,792 Healthy Steps premiums were paid; an increase of 206 from the previous year.//2013//

Caring Program: The Caring Program for Children provides free health and dental care for children up to age 19 years old who are not covered by or eligible for Medicaid or Healthy Steps and have no other insurance. Eligibility requirements are at 200% of the Federal poverty level.

1-877-KIDS-NOW is a toll-free resource line that helps uninsured families learn about low-cost and free health coverage programs in ND. A seamless eligibility process for these three health coverage programs has helped to assure coverage for ND's children.

Comprehensive Health Association of North Dakota (CHAND): The CHAND program is designed to provide health insurance to ND residents who have been denied health insurance or are considered high risk.

Current Priorities/Initiatives and the Resulting Title V Program's Roles and Responsibilities

John Hoeven was sworn in as the state's 31st Governor in December 2000 and began working to build North Dakota's (ND) future by focusing on six pillars of growth: education, economic development, agriculture, energy, technology and quality of life.

Protecting ND's citizens and communities has been an important focus of many of Hoeven's policies and initiatives, including the introduction of new laws to strengthen the states violent and sexual offender statutes, and the expansion of ND's efforts to combat substance abuse, while helping young people involved with drugs through rehabilitative programs such as ND's Drug Courts.

In his third term, Hoeven remains committed to enhancing the state's business climate, reducing taxes and promoting a higher standard of living and a better quality of life for all North Dakotans. Building on previous initiatives, he has advanced new incentives for economic development, renewable energy, and research and development, as well as additional investments in education, including increases for teacher compensation, education equity and adequacy, and expanded funding for Centers of Excellence, an initiative that combines education and economic development to create higher-paying jobs and new business opportunities for ND citizens.

In 2002, Governor Hoeven announced a new public health initiative, Healthy North Dakota (HND). HND is a dynamic, statewide partnership that brings together partners and stakeholders to identify common strategies to address health issues. HND's framework supports North

Dakotans in their efforts to make healthy choices by focusing on wellness and prevention -- in schools, workplaces, senior centers, homes and anywhere people live, learns, work and play. Today, HND is a dynamic, statewide partnership with over 400 committee members working together and finding solutions for healthier living. Many Title V/MCH staff and programs are engaged with HND committees/coalitions such as Breastfeeding, Cancer, Coordinated School Health, Diabetes, Early Childhood Comprehensive Systems (ECCS), Health Disparities, Healthy Weight, Injury Prevention, Nutrition, Oral Health, Physical Activity, Tobacco and Worksite Wellness. These partnerships create a unique opportunity for Title V staff/programs to communicate our priorities and leverage resources.
/2012/ After serving as Governor of ND for 10 years, John Hoeven was sworn in as ND's 22nd U.S. Senator on January 5, 2011. As a result, Lieutenant Governor, Jack Dalrymple was sworn in as the 32nd Governor of ND on December 7, 2010. He remains committed to managing the state with fiscal responsibility and with a new emphasis on infrastructure improvements and energy development. He brings to the office an outstanding record of farming, business, legislative and executive leadership.

Drew H. Wrigley was sworn in as ND's 37th Lieutenant Governor on December 7, 2010. He serves as President of the ND Senate and as point person for the Governor's Office on key legislative and policy initiatives.//2012//

First Lady Mikey L. Hoeven has been deeply committed to addressing women and children's issues in the state of ND. She is especially active in women's health, the prevention of underage drinking and is the official spokesperson for HND. Mrs. Hoeven hosts two annual statewide Women's Health Summits that address the most recent health issues affecting women of all ages. The state Title V director is a member of the planning committee for these summits.
/2012/ Betsy Dalrymple became First Lady of ND on December 7, 2010, when Governor Jack Dalrymple was sworn in as Governor. She has a long career of public service and is especially interested in early childhood education and volunteerism. Members of the HND Early Childhood Alliance have met with Ms. Dalrymple to discuss early childhood issues and needs.//2012//
/2013/ The Title V director met with ND First Lady, Betsy Dalrymple, along with SD's First Lady, Linda Daugaard, to discuss strategies to reduce infant mortality. Subsequently, the Title V director was invited to present ND's strategies to reduce infant mortality to SD's Infant Mortality Task Force in September 2011. As a result, SD has implemented the Cribs for Kids Safe Sleep Program.//2013//

The mission of the North Dakota Department of Health (DoH) is to protect and enhance the health and safety of all North Dakotans and the environment in which we live. To accomplish our mission, the DoH is committed to improving the health status of the people of ND, improving access to and delivery of quality health care, preserving and improving the quality of the environment, promoting a state of emergency readiness and response, and achieving strategic outcomes within available resources. The North Dakota Department of Health values excellence in providing services to the citizens of ND; credibility in providing accurate information and appropriate services; respect for our employees, our coworkers, our stakeholders and the public; creativity in developing solutions to address our strategic initiatives; and efficiency and effectiveness in achieving strategic outcomes.
/2013/ The DoH is starting the process for public health department accreditation. The Public Health Accreditation Board Standards and Measures were reviewed between February and May 2012. Gaps and weakness were identified that will assist the DoH as the application process continues. The goal for DoH is to submit the finalized application by December 2014.//2013//

In December 2005, the DoH started a strategic planning process. As a result of this effort, Strategic and Business Maps were developed that identify the Department's mission, strategic initiatives, key objectives and indicators. These maps assist the Department in communicating with partners, setting direction, motivating employees, making decisions, determining priorities and budgets and monitoring progress and impact. Both the Title V and Children's Special Health

Services (CSHS) directors were actively involved in this process. Several Title V-related measures were used as indicators for success in the plan.
/2012/ During the summer of 2010, several strategic planning meetings were held to update the Strategic and Business Maps to reflect current and emerging priorities for the period of 2011-2015. The Title V and CSHS directors continued to be actively involved in this process.//2012//
/2013/ In preparation for the 2013 Legislative Session, meetings are being held in June and July 2012 to review and revise, as appropriate, the DoH's Strategic and Business Maps. The impact of oil and other public health challenges (e.g., flooding, etc.) have already been added as a cross-cutting key objective. The Title V and CSHS directors continued to be actively involved in this process.//2013//

A copy of the DoH's strategic plan can be accessed at the following URL:
http://www.ndhealth.gov/DoH/Overview/DeptStrategicPlan.pdf

A copy of the DoH's business plan can be accessed at the following URL:
http://www.ndhealth.gov/DoH/Overview/DeptBusinessPlan.pdf

ND's Title V statewide needs assessment process for FY's 2011-2015 began in the summer of 2009 and continued through June 2010. Title V staff were actively engaged in all aspects of the planning and took leadership roles in the areas of survey development and implementation; data presentations; and the development of performance measures. The Title V and CSHS directors use this process to determine what the current and emerging issues are and to assist with the prioritization of the many competing factors that impact health services in the state.

A detailed description of the Needs Assessment process can be found in Section II. Needs Assessment. The following ten priorities were identified through the statewide needs assessment process: 1) Form and strengthen partnerships with families, American Indians and underrepresented populations, 2) Form and strengthen a comprehensive system of age appropriate screening, assessment and treatment for the MCH population, 3) Support quality healthcare through medical homes, 4) Increase participation in and utilization of family support services and parent education programs, 5) Increase access to available, appropriate and quality health care for the MCH population, 6) Promote optimal mental health and social-emotional development of the MCH population, 7) Increase the number of child care health consultants and school nurses who provide nursing health services to licensed child care providers and schools, 8) Reduce violent behavior committed by or against children, youth and women, 9) Reduce the rate of deaths resulting from intentional and unintentional injuries among children and adolescents, and 10) Promote healthy eating and physical activity within the MCH population. Title V resources are directed toward these ten priority areas.
/2012/ ND's Five-Year Needs Assessment document can be viewed at http://www.ndhealth.gov/familyhealth/publications/NDNeedsAssessment2011-2015.pdf //2012//

Priority setting also is determined by state mandates. The testing and treatment of newborns (ND Century Code [CC] 25-17), the Sudden Infant Death Syndrome Program (NDCC 23-01-05) and Children with Special Health Care Needs (CSHCN) (NDCC 23-41.01-07) are state mandates. Title V staff have the responsibility for caring out these programs. In addition, activities related to the Abortion Control Act (NDCC 14-02.1) for the creation and distribution of printed materials are assigned to Title V staff.

ND's Legislative Assembly convenes every other year, on odd years. The 62nd Legislative Assembly will organize December 6-8, 2010, and will convene in regular session Tuesday, January 4, 2011. Many Title V-related coalitions and partners are already in the planning process to set legislative priorities. In May 2010, the Coordinated School Health Program hosted a priority setting workshop with its partners to identify policy and environmental strategies and identified increasing the number of school nurses and seeking funding as major goal; which is directly linked to the Title V priority #7 (see above). ND EHDI is North Dakota's Early Hearing Detection and Intervention Program (EHDI), which provides hearing screenings to all ND newborns at all

birthing hospitals and refers those identified with a hearing loss to appropriate resources for intervention. CSHS tracks the screenings and integrates other newborn screening and immunization information, as discussed in Title V Federal Performance Measure #12. Many other programs/coalitions are planning on hosting or participating in similar meetings. Because Title V staff are experts at partnerships, are involved at multiple levels and have a broad understanding of linkages, they will play a key role in these discussions.
/2012/ In preparation to the 2011 legislative session, sections within the DoH were required to submit a general fund hold-even budget. They were also asked to identify three percent in optional savings in the event cuts were needed. Any additions, including all new full-time equivalent positions, had to be requested through an optional budget package.

The 2011 ND Legislative Assembly convened in regular session on January 4th and adjourned April 28th. The session posed many challenges due to several factors including the legislative make-up (republican dominated), state and national politics, health care reform, reduced or ignored fiscal notes, complex public health issues such as universal immunizations, and issues relating to the oil boom. The session can be summarized by a quote from DoH Deputy State Health Officer Arvy Smith in a May 2011 DoH newsletter, "this was without a doubt the most grueling, dramatic legislative session I have experienced in the past 21 years".

Numerous bills relating to the MCH population were considered by the Legislature. Several pieces of legislation were passed that will positively effect the MCH population including updates to the metabolic screening law; improved safety for teen drivers (graduated driver's license law); pharmacists' ability to vaccinate children; state funds for suicide prevention; increased state funding for local public health; anti-bullying laws; concussion management for student athletes; a ban on texting while driving; early childhood facility grants; funding to support childcare providers recruitment, training, and retention; child care inclusion grants for children with special health care needs; a pilot study for detection of autism and early intervention; changing the term mental retardation to intellectual disability in state law; implementation of federal health care reform; Department of Human Services appropriations that maintain services for individuals with disabilities; and DoH authority to release limited birth and death information for a statewide longitudinal data system.

Legislation not passed that would have supported the MCH population includes an increase to the income eligibility for the children's health insurance program; expanded Medicaid coverage to pregnant women; additional funding for Head Start; funding to support school nursing; a Healthy School Program that would have supported improvements in physical activity and nutrition, the instruction of CPR, and the maintenance of automatic external defibrillator in schools; ATV safety certification for children under 12 years of age; a study and plan for restructuring the human services delivery system in the state; a study of department programs for catastrophic diseases; and expansion to the food program for individuals with metabolic diseases.

The biggest disappointments were the removal of funding for programs supported by health care reform legislation including the Maternal, Infant and Early Childhood Home Visiting Program; the Abstinence Education Program; and a program that would have supported a short-term public health improvement position to work on public health accreditation. Some legislators have stated that programs linked to health care reform funding will be discussed again during a November 2011 special legislative session.

Another disappointment was a bill which attempted to bring ND back to universal vaccination status. While the bill passed, the final version provided government funded vaccines to local public health units only, possibly effecting children receiving needed services in their medical homes.

There were also several bills that mandated the DoH fulfill legislative requirements including the development of a brochure containing information on umbilical cord blood donation, and updates to the Abortion Control Act that revises current publications and adds two new publications

relating to support obligations of fathers and medical risks associated with surgical and medical abortions. All of these publications are assigned to the Title V director's Division of Family Health for completion. Fiscal notes were provided for these bills, but no state funds were allocated; hence, Title V MCH funding will be used to develop, print and distribute the publications.

Seventy-two studies were proposed for consideration during the legislative session to be considered for the interim. Some of the selected 40 studies relevant to MCH include the impact of the federal Patient Protection and Affordable Care Act and rules adopted by federal agencies as a result of that legislation; a study of concussion management with respect to youth athletics to prevent or eliminate concussions; the ability of the University of ND School of Medicine and Health Sciences to meet the health care needs of the state; a study of the regional public health network pilot project conducted during the 2009-2011 biennium including efficiencies and cost-savings to state and local governments; a study of the future of health care delivery in the state, focusing on the delivery of health care in rural areas of the state which will include input from the School of Medicine and Health Sciences Center for Rural Health, hospitals, and the medical community; a study of the current system for the diagnosis of, early treatment of, care of, and education of individuals with autism spectrum disorder; and a study of the feasibility and desirability of placing the entire Fort Berthold Reservation in a single public health unit.

Studies not selected included the evaluation of positive and negative impacts of implementation of patient-centered medical homes; a study to improve health care services provider's access to third-party reimbursement network systems to contain health care costs and out-of-pocket expenses; and a study to examine the delivery of early childhood services and programs (the DoH's Early Childhood Comprehensive Systems Program was named in this study).

One final outcome of the legislative session is a required performance audit of the Division of Family Health (the division the Title V director manages) during the period of July 1, 2011 through June 30, 2013. The target of the audit is unknown at this time.//2012//
/2013/ The Performance Audit of the Division of Family Health was completed and presented to the Legislative Audit and Fiscal Review Committee on June 21, 2012. Three key recommendations were reviewed including the development of a whistleblower protection policy in the DoH's Personnel Policy Manual; additional developmental trainings for program managers and division directors that are included in the DoH's Personnel Policy Manual; and a DoH procedure to centrally track and monitor transfers of expenditures within the same grant or to another grant.

The Title V Director has provided testimony at three interim Health Services Committee meetings on the DoH's responsibilities as it relates to Section 15 of 2011 House Bill 1297 (amendments to the Abortion Control Law). The Title V Director has responsibility for the educational materials of the law. A booklet informing women of the anatomical and physiological characteristics of the unborn child; support obligations of the father; and information on the various surgical and drug-induced methods of abortion is currently being updated to meet requirements of the law.

Interim Human Services Committee meetings have been attended to monitor the study of Autism Spectrum Disorders. Recommendations that had been prioritized from the State Autism Spectrum Disorders Task Force were presented along with biennial cost estimates for implementation. Family representatives and other interested stakeholders have also provided testimony on a consistent basis.

The DoH's Public Health Liaison works closely with ND's State Association of City and County Health Officials (SACCHO). Local public health priorities identified for the 2013 legislative session include 1) Increased state aid to supplement communicable disease funding cuts; 2) Regional Public Health Networks with a focus on environmental health; 3) Oil impact; 4) Universal immunizations; and 5) Maintenance of tobacco prevention funds.

The DoH's Office for the Elimination of Health Disparities director has been actively involved in Fort Berthold Study Bill meetings, which are exploring placement of the entire Fort Berthold Reservation in a single public health unit. Others involved in the discussions and planning include the Chairman of Three Affiliated Tribes and his staff, and local public health unit representatives from Dickinson, Williston and Minot.//2013//
An attachment is included in this section. IIIA - Overview

B. Agency Capacity

The following section describes the State Title V agency's capacity to promote and protect the health of all mothers and children, including Children with Special Health Care Needs (CSHCN).

State Program Collaboration with Other State Agencies and Private Organizations

ND has many strong collaborative partnerships working at the state level. Title V staff actively participate on a variety of alliances/committees/coalitions/task forces that impact the health of mothers and children, including those with special health care needs. Communication and collaboration between these many groups is assured through the Healthy North Dakota (HND) Coordinating Committee. Membership includes the chair or liaison from each of the groups. The Committee meets every other month with the goal to identify common strategies and strengthen collaborations to address priority health issues.

State Support for Communities

State Maternal and Child Health (MCH) support for communities is addressed through contracts with 27 local public health units, three nonprofits, two tribal entities and one university. The funds are used for services such as maternal care, well-baby clinics, newborns home visits, genetics, car seat safety programs, school health/wellness, nutrition and physical activity education, injury prevention, immunizations and oral health care.

The state CSHCN program supports cooperative administration of programs for children with special health care needs with 53 county social service boards. County agencies receive reimbursement based on a Random Moment Time Study method of cost allocation. In addition, CSHCN support for communities is addressed through contracts with a variety of entities that provide multidisciplinary clinics, community-based care coordination, and family support services.

For tables depicting uses of Title V funds at the local level for FY 2013, refer to the following URL http://www.ndhealth.gov/familyhealth/grantees/fy2013/FY13UseOfTitleVFunds.pdf

Coordination with Health Components of Community-based Systems

MCH contracts awarded to local entities assure coordination with community-based systems. For CSHCN, multidisciplinary clinics are one of the mechanisms by which comprehensive health components are successfully coordinated. Many disciplines participate in team clinics, which are held at various locations throughout the state in order to provide comprehensive care to CSHCN's and their families. Staff members in the state CSHCN program facilitate an annual meeting with lead clinic coordinator staff and provide ongoing technical assistance upon request to promote system enhancements.

Coordination of Health Services with Other Services at the Community Level

Many programs support Coalitions whose membership consists of community-level service providers (e.g., Oral Health Coalition -- Safety-net Dental Clinics, Healthy ND Early Childhood Alliance -- Parent Resource Centers, Interagency Coordinating Council, etc.). Regional infrastructure that enhances coordination between health and other services and addresses quality improvement and community mobilization is also supported through Title V partnership

activities (e.g., regional Interagency Coordinating Council's, Parent Navigator Teams, Regional Education Association's, etc.).

Lastly, community-based care coordination services provided on behalf of CSHCN and their families also assure coordination of health services with other services at the community level. The state CSHCN program promotes and supports partnerships to enhance care coordination infrastructure development (e.g., medical home care coordination training curriculum).

Statutes and Their Impact

The State Health Officer (SHO) of the ND Department of Health (DoH) is responsible for the administration of programs carried out with allotments made to the state by Title V.

The DoH functions in compliance with Chapter 28-32, Administrative Agencies Practice Act, ND Century Code (N.D.C.C.). The Divisions of Family Health, Injury Prevention and Control (IPC) and Nutrition and Physical Activity (NPA), within the Community Health Section, and the Division of Children's Special Health Services (CSHS) within the Special Populations Section have statutory authority to accept and administer funds for the following programs: MCH/Title V -- including CSHCN, WIC, Family Planning/Title X and Domestic Violence (both state general and marriage license surcharge). The MCH/Title V and Family Planning/Title X are administered within the Division of FH. The WIC Program is administered within the Division of NPA. The Domestic Violence Program is administered within the Division of IPC. The Governor named the DoH the lead agency for the STOP Violence Against Women Program contained in the federal crime bill. The Division of IPC administers the STOP Program. The N.D.C.C. mandates donated dental services (23-01-27), newborn metabolic screening (23-01-03.1 and 25-17- 01 to 25-17-05) and SIDS reporting (11-19.1). All three of these programs are located in the Division of FH. /2012/ The Division of FH also has responsibility to develop and distribute printed materials as required in the Abortion Control Act, N.D.C.C. Chapter 14-02.1-02.1.//2012//

In addition, N.D.C.C. 23-01-34 mandates Title V program administration for CSHCN. Chapter 23-41 addresses administrative duties of state and county agencies, confidential birth reports for newborns with visible congenital deformities, and services for individuals with Russell Silver Syndrome. Chapter 25-17 addresses provision of medical food and low-protein modified food products.

Description of Title V Capacity

Preventive and Primary Care Services for Pregnant Women, Mothers and Infants

The Family Planning Program (FPP) provides reproductive health-care services to men and women, giving preference to low-income, adolescent and women-in-need populations. Services include Pap smear, breast exam, testicular exam, infertility level-one services, pregnancy planning, a broad range of birth control methods including abstinence, and STD and HIV testing and counseling.

The FPP is included as a constituent program represented on the MOU with the ND Department of Human Services (DHS) to assure quality and accessible care to improve the health status of children with special health care needs, pregnant women, mothers, infants and children, especially those who are disadvantaged.

The FPP Director is a member of the Tobacco Partnership, which includes representatives from the Tobacco Program, WIC Program, Optimal Pregnancy Outcome Program and an OB/GYN physician. The goal of this partnership is to strategize avenues to prevent and/or reduce the use of tobacco by women of reproductive age. In addition, she serves as a member of a stakeholders group with representation from the HIV/AIDS program and the Office for the Elimination of Health Disparities within the DoH, the Indian Affairs Commission and the Department of Public

Instruction with the primary goal of collaboration with American Indian communities to identify needs for behavioral interventions to improve sexual health for youth.

The FPP receives supplemental funding from Title V to assist in the support of state administrative functions.
/2012/ Special initiative funding was received in FY 2010 to support a male services campaign. The FPP received a nine percent reduction in funds for FFY 2011.//2012//
/2013/ The FPP funding formula used was revised with more weight to clients served at or below 250 percent of poverty.//2013//

The Newborn Metabolic Screening (NBS) Program identifies infants at risk and in need of more definitive testing to diagnose and treat affected newborns. Program objectives include assurance that all infants testing outside of normal limits received prompt and appropriate confirmatory testing, and the development and provision of education to health care providers, families and communities. Over 40 conditions/disorders are included in the NBS profile. ND's testing and short-term follow-up are performed by the University of Iowa's Hygienic Laboratory in Des Moines. The ND NBS Program Director serves as the ND/Iowa regional follow-up coordinator focusing on quality assurance and education.

The NBS Program has an advisory committee that meets quarterly to provide recommendations on such issues as policy/protocol development and proposed conditions/diseases to be screened for. The Advisory Committee membership includes the SHO, the NBS Program Director, the State Title V Director, the State CSHCN's Director, a geneticist, a neonatologist, a pediatric endocrinologist, an OB/GYN nurse educator, a hospital association executive, the Iowa lab director, the Iowa metabolic consultant, pediatricians, family practice physicians, and a parent representative. Currently, the advisory committee is discussing options for the storage and retention of blood spots.
/2012/ Changes to the newborn screening law during the 2011 legislative will allow ND to add conditions/disorders to the screening panel through the administrative rule process. Assurance that physicians provide parents with written information regarding the screening process was also added.//2012//
/2013/ A blood spot storage and retention policy is being developed. SCID and CCHD are being reviewed for possible inclusion in the newborn screen.//2013//

The Optimal Pregnancy Outcome Program (OPOP) provides multi-disciplinary teams (nursing, social and nutritional services) committed to enhance the prenatal care women receive from their primary health care provider. The team utilizes opportunities to nurture the pregnant woman's self esteem, self-confidence, and reinforce her important role and responsibility in having the healthiest baby possible. The outcome goals for OPOP include increased birth weights, decreased incidence of low weight births, decreased incidence of small for gestation age, pre-term labor prevention/early recognition, decreased occurrence of preventable congenital anomalies, decreased incidence of large for gestational age, reduction of morbidity of pregnancy, enhanced maternal/infant bonding to increase mothers commitment to positive pregnancy outcome, increased breastfeeding to benefit mother and infant, increased availability and access to comprehensive prenatal care services, facilitation of early entry and access into medical prenatal care, and empowerment to make healthy lifestyle choices. Eight sites throughout the state provide OPOP services.
/2012/ Two OPOP sites have discontinued services due to budget reductions.//2012//

The Cribs for Kids Program (a National Infant Safe Sleep Initiative) provides infant safe-sleep education and portable cribs to pregnant women to help reduce the risk of injury and death of infants due to unsafe sleep environments. Established in 2009, this program was piloted through the OPOP. An overwhelming about of need has resulted in the program expanding to Healthy Families and to two tribal entities. Limited funding at the current time is limiting further expansion. State funds to support the program will be requested during the 2011 legislative session. The MCH Nurse Consultant manages this program.

/2012/ Funding to sustain the program was received through the MCH and ECCS grants allowing continued expansion to American Indian and evidence-based home visiting programs.//2012//
/2013/ Expansion continued to include two additional American Indian sites, for a total of 15 partner sites statewide.//2013//

The Sudden Infant Death Syndrome Program (SIDS) provides support, education and follow-up to those affected by a sudden infant death. In the belief that every child should live, ND enacted legislation in 1977 that prompted the development of the ND SIDS Management Program. The SIDS Management Program provides: a system for reporting suspected SIDS cases to the DoH; provision for payment of autopsies; support and counseling to families of SIDS victims; the use of the term "sudden infant death syndrome" where appropriate on death certificates; and distribution of information about SIDS to health-care professionals and the concerned public.

The MCH Nurse Consultant is the SIDS Program Director. She maintains collaboration with the local SIDS Affiliate, public health and Child Care Resource and Referral to implement and coordinate a safe sleeping environment for infants/children under the age of one. In an effort to increase education and provide families with safe sleep environments, the Cribs for Kids Program was established -- as described above.
/2013/ The SIDS Program director dedicates 50 percent time to the program. The other 50 percent of time, she provides assistance to the NBS Program director, thereby leveraging resources to improve infant health outcomes.//2013//

The Women's Health Program acts as a catalyst to facilitate increased awareness of the importance of women's health through discussion of issues and gaps in service and enhance availability of services through cross referral between programs providing services to women. The FPP Director serves as the Women's Health State Coordinator.

The First Lady hosts two Women's Conferences annually in which the Title V director serves on the planning committee.
/2013/ The last Women's Health Conference was held June 2013.//2013//

Preventive and Primary Care Services for Children

Local agencies, including public health agencies, conduct primary preventive health services for the child and adolescent populations.

The Coordinated School Health (CSH) Program provides consultation and technical assistance for schools and school nurses to use in organizing and managing school health and wellness initiatives. The goal of this program is to build state education and health agency partnership and capacity to implement CSH programs across agencies and within schools. The CSHP director also serves as the State School Nurse Consultant.
/2012/ The CSH director has transitioned to the MCH Nurse Consultant position, but maintains her role as the State School Nurse Consultant.//2012//
/2013/ A new CSH Program director was hired. She splits her time between CSH and MCH, thereby leveraging resources for child and adolescent health.//2013//

A CSHP Coordinator has been placed in the Southeast Regional Education Association (REA) to implement CSHP. REAs have been formed throughout the state to improve educational services to students and to enhance cooperation in communities and geographic regions. The Southeast REA includes 18 school districts. Major accomplishments include the completion of an environmental scan relating to physical activity, nutrition and tobacco; implementation of school health councils; and the establishment of a CSH Summit.

A School Health Interagency Workgroup (SHIW) made up of staff from the Department of Transportation, DPI, DHS and DoH meets every other month to collaborate and coordinate on issues pertaining to school health. In addition, the SHIW serves as an advisory committee for the

Youth Risk Behavior Survey (YRBS) regarding question inclusion and data dissemination.

The Early Child Comprehensive Systems (ECCS) Program supports collaborations and partnerships that support families and communities in their development of children who are healthy and ready to learn at school entry. The goal of this program is to build early childhood service systems that address access to health insurance and medical home, mental health, early care and education/child care, parent education, and family support. The Healthy ND Early Childhood Alliance has over 90 stakeholders that work together to implement the ECCS state plan. The ECCS Program Director is an active member in the Governor's Early Childhood Education Council.
/2013/ The ECCS Program received a one year extension with funds to continue program efforts through May 31, 2013.//2013//

The Injury/Violence Prevention Program has as its overall goals to reduce both unintentional and intentional injuries, with special emphasis on children and women. The program uses a variety of best practice strategies, including primary prevention theories, data collection and analysis, designing and developing interventions, training and technical assistance, policy advocacy, and evaluation. Injury prevention activities include seat belts, child passenger safety, bike helmets, home and product safety, poison control, suicide prevention and other injury-specific topics. Program staff provide training, technical assistance, educational materials and safety products to local entities to implement community-based intervention projects.

During the 2009 legislation session, $250,000 of general funds was received for suicide prevention activities. Contracts have been awarded to four tribal entities and two rural communities, and mini grants are planned to be distributed to various communities. A portion of the funding also went to support the state's 2-1-1 toll-free line; a statewide information, referral, and crisis management service.
/2012/ During the 2011 legislative session, $991,493 in general funds were received for suicide prevention.//2012//

The MCH Nutrition Program provides consultation and technical assistance, monitors nutrition data, plans and evaluates nutrition programs, coordinates nutrition related activities, and acts as a clearinghouse for nutrition information and training. The State MCH Nutrition Services Director is 100 percent funded through Title V. There are 19 nutrition contacts working through local public health units on activities such as partnering through HND committees (e.g., Breastfeeding Committee); the Healthy Eating and Physical Activity Partnership; and promoting nutrition and physical activity for women, children and families as well as to the community as a whole.

The Oral Health Program provides prevention programs, education, access, screening and consultation to address the oral health needs of North Dakotans. Program staff collaborates with public and private groups to assure policy/program development with an emphasis on improving access to oral health care. Prevention programs include School Fluoride Mouth Rinse, Seal! ND and Healthy Smiles Fluoride Varnish. Additional services include community water fluoridation, dental access programs, donated dental services, dental loan repayment, oral health education and oral health surveillance. State oral health staff assists the Oral Health Coalition by providing administrative and evaluation support, facilitating communication and maintaining a web page.

The Oral Health Program submitted a grant application to support oral health workforce activities. Grant goals included working with one dental safety net clinic to increase services to the elderly, and assisting with the establishment of a Dental Care Mobile and statewide sealant program to serve children is rural ND. If funded, the projected award date is September 1, 2010.
/2012/ Funding was awarded and all grants goals are being implemented.//2012//
/2013/ The Oral Health Program was awarded a one year DentaQuest Foundation Grant to create a strategic plan. A two-year grant application for implementation has been submitted.//2013//

Additional Programs

During the 2009 legislative session, general funds were received to provide fetal alcohol syndrome prevention, support donated dental services and assist in the planning and implementation of a dental care mobile. All of these funds are awarded through contracts and administered by the Division of Family Health/Title V.
/2012/ During the 2011 legislative session, general funds were received to continue the fetal alcohol syndrome prevention project and donated dental services. The dental care mobile is scheduled to start providing services in December 2011.//2012//
/2013/ The Dental Care Mobile started providing services in February 2012 with 324 patient visits in the first two months of service.//2013//

ND Governor John Hoeven has designated the DoH, Division of Family Health/Title V as the administrating agency for the Maternal, Infant and Early Childhood Home Visiting Program. Collaborative efforts are well under way to complete the first FOA (due July 9, 2010) and Needs Assessment (due September 1, 2010). A key stakeholder meeting was held on June 24, 2010 with over 30 participants to begin the planning process.

The DoH, Division of Family Health/Title V has also been given the authority to apply for the restored Title V Abstinence Education Grant Program. We are currently waiting for the grant guidance to be released.
/2012/ Home Visiting and Abstinence funding were removed from the DoH's budget during the 2011 legislative session.//2012//
/2013/ Collaboration continues around home visiting that is led by Prevent Child Abuse ND (PCAND). Title V staff participate in PCAND's Home Visiting Coalition. PCAND will be submitting an application to provide services under the Maternal, Infant, and Early Childhood Home Visiting grant program.//2013//

Discussion between agencies as to the appropriate designee is occurring in anticipation of the State Personal Responsibility Education Program (PREP).
/2012/ No PREP funding was received in ND.//2012//

Program Support

Title V programs are supported by section Information Technology and a grants management specialist. Epidemiologists for MCH, the State Systems Development Initiative (SSDI), and the Behavioral Risk Factor Surveillance System (BRFSS) also provide ongoing support.

Services for CSHCN

a. To provide rehabilitation services for blind and disabled individuals under the age of 16 receiving benefits under Title XVI (SSI), to the extent medical assistance for such services is not provided under Title XIX (Medicaid)

State CSHCN program staff conduct outreach, information and referral activities targeted to the SSI population. On a monthly basis, Disability Determination Services (DDS) provides referrals electronically to the state CSHCN program. In response, state CSHCN staff provide a direct mailing to families notifying them about potential programs that could be of assistance. This assures that children are consistently being referred to the Title V program and that families receive information about program benefits and needed services.

ND is a 209(b) state, which means SSI beneficiaries under 16 years of age are not automatically eligible for Medicaid. If assets are an issue affecting Medicaid eligibility, children eligible for SSI can be covered under the children and family coverage groups where asset testing is not required. The state CSHCN program also pays for or provides rehabilitative services for eligible children that are served by Title V.

The State's Federal Computer Matching and Privacy Protection Act agreement with the State expired June 30, 2007. These agreements allowed the Social Security Administration (SSA) to provide certain data on individuals to the State without the individuals consent for use in making eligibility determinations for certain health and income maintenance programs. Effective July 1, 2007, CSHS lost access to SSI information through the SDX and SOLO-Q systems. A Request for Disclosure of SSA Information for Use in Non-1137 Programs was submitted for review by policy and legal staff in the SSA but was denied effective July 18, 2008. SSA staff determined that access to the data was for administrative purposes rather than to determine entitlement of applicants to health and income maintenance programs so access to SSA-related information was prohibited without the written consent of the individual. With this change, access to SSI data became more problematic. State staff continue to review published reports from the SSA and collect data on the SSI status of children served based on information reported by families through the care coordination planning process.

Annually, state CSHCN staff convene a meeting between DDS, the local SSA office, Medicaid and Family Voices to jointly monitor the status of the SSI population and assure communication about any new developments that have occurred or that are expected during the year. See Section III.F, Health Systems Capacity Indicator #08, for more information.
/2012/ Over the last three years, the State CSHS program served an average of 8.8 percent of the SSI child population under the age of 16. CSHS staff responded to 449 referrals that were received from DDS. An annual SSI meeting was held on 1/26/11. //2012//
/2013/ The State CSHS program served an average of 16.2 percent of the SSI child population under the age of 16, a substantial increase due to an effective electronic referral process implemented in 2009. CSHS staff responded to 458 referrals from DDS. An annual SSI meeting was held April 2012.//2013//

b. To provide and promote family-centered, community-based, coordinated care including care coordination services, for CSHCN and facilitate the development of community based systems of services for such children and their families

Efforts to enhance family-centered care include support of a CSHS Family Advisory Council that assures family involvement in policy, program development, professional education, and delivery of care; a service contract with Family Voices of ND to assure access to emotional support, information, and training for families; active state CSHCN staff involvement with other related initiatives that support family/professional collaboration; and quality improvement strategies that focus on family satisfaction with services.
/2012/ CSHS began supporting a Hands & Voices Chapter serving ND and eastern MT. This organization provides support, education, and resources for families and children within the deaf and hard of hearing community.//2012//
/2013/ CSHS recently appointed a father to the Family Advisory Council.//2013//

The following section describes programs administered by the State CSHCN program.

Specialty Care Diagnostic and Treatment Program -- CSHS helps families pay for medical services for eligible children, including health-care visits and tests to diagnose chronic health conditions early and specialty care needed for treatment. Families apply for services at their county social service office. County staff help determine financial eligibility. Income eligibility is mandated at 185 percent of the federal poverty level for treatment services through CSHS. Assets are not considered. The CSHS Medical Director determines medical eligibility at the central office based on a list of eligible medical conditions, which is developed with the help of the CSHS Medical Advisory Council. Other state-level CSHCN staff develop policy and procedures, provide technical assistance with the application process, conduct training for county social service staff, process claims payments for eligible children using the Medicaid Management Information System, and coordinate benefits between third party payers. The unit also maintains a list of qualified health care providers who have been approved to participate in the program.

/2012/ Medical eligibility for this program has been expanded slightly. CSHS served close to 325 children during FY 2010.//2012//
/2013/ CSHS served 325 children and their families during FY 2011. Minor expansions in medical eligibility and covered services were implemented.//2013//

Multidisciplinary Clinics -- CSHS funds and administers clinics that support coordinated management of ten different types of chronic health conditions. Clinics provide access to pediatric specialty care and enable families to see many different medical providers and health-care professionals in one place at one time. CSHS directly administers or funds clinics for the following 10 conditions: Cleft Lip and Palate, Cardiac, Metabolic Disorders, Cerebral Palsy, Developmental Assessment, Myelodysplasia, Diabetes, Neurorehab, Autism, and Asthma. State CSHCN nursing staff coordinate two of the clinic types while others are provided through contracts with health systems, hospital foundations, universities, or other not-for-profit entities. For the latter, state CSHCN staff provide technical assistance, conduct quality assurance activities, and convene an annual meeting for clinic coordinator staff from across the state to assure communication about any new developments that have occurred or that are expected during the year. A network of public and private health care providers across the state participate in the multidisciplinary clinic program, including local county social workers affiliated with CSHS who staff some of the clinics. Clinics provide a secondary benefit as an avenue for pre-service training in the state, particularly for nursing and speech/language students.
/2012/ CSHS served over 1,100 children through this program. Although the types of clinics that CSHS supports has remained the same, an additional developmental clinic site has been added in ND's largest city of Fargo.//2012//
/2013/ CSHS served about 1,200 children through this program.//2013//

Metabolic Food Program -- CSHS provides medical food and low-protein modified food products to individuals with phenylketonuria and maple syrup urine disease. State mandates require that males under age 22 and females under age 45 receive formula at no cost while others outside those age groups can receive formula at cost. Low protein modified food products are also provided at no cost to males under age 22 and females under age 45 who are receiving medical assistance when its determined medically necessary. State-level CSHCN staff develop policies and procedures that guide the program, maintain an on-site inventory, fill client orders upon request, provide a variety of state-level care coordination services, and carry out other general administrative duties required to implement the program.
/2012/ CSHS served close to 25 individuals through the metabolic food program. Legislation to expand these services failed during the 2011 session.//2012//
/2013/ CSHS continued to serve about 25 individuals through the metabolic food program.//2013//

Russell-Silver Syndrome (RSS) Program -- CSHS pays for growth hormone treatment and medical food for individuals through age 18 with RSS who are enrolled in the program. The 2005 Legislature mandated that services be provided at no cost regardless of income. Care is limited to $50,000 per child each biennium. Enrollment and claims payment activities are completed in a similar manner as previously mentioned under the Specialty Care Program.
/2013/ Four children are currently enrolled in the RSS program.//2013//

Care Coordination -- CSHS supports community-based programs to help families who have children with special health-care needs access services and resources. Partners include county social services and local public health. A public health nurse provides care coordination services to a broad population of children with physical, developmental, behavioral or emotional conditions in Grand Forks County. County social service staff in all 53 counties of the state provide care coordination services for children eligible for treatment services through CSHS. State-level staff provide technical assistance/training and conduct quality assurance activities to support these local programs.
/2012/ Local staff continue to provide services. CSHS provided funding to support care coordination within medical home pilot practices. State staff also supported development of a

care coordination training curriculum and helped organize a training event on health benefits counseling.//2012//
/2013/ CSHS continues to provide funding to support care coordination services. CSHS staff provided input for the document Medical Home Certification for Providers Serving Children and Youth with Special Health Care Needs.//2013//

Information Resource Center -- CSHS provides health-care resource information to families and service providers free of charge. In addition, division staff conduct a variety of public information services that focus on the following: toll-free number; targeted outreach, information and referral; resource library; education and consultation; marketing; and system-related activities.
/2012/ Around 1,000 families receive information and referral services each year through CSHS.//2012//
/2013/ CSHS provided information and referral services to about 1,000 families during the year.//2013//

State Systems Development Initiative (SSDI) -- CSHS enhances data infrastructure that is needed to meet the needs of the MCH population and provides data about the population of children with special health care needs and their families. Current SSDI grant activities address identified gaps by enhancing collection, analysis, synthesis, translation, technical assistance, training and dissemination of data as well as building data capacity at the state and local level.
/2012/ Publications related to the Title V MCH needs assessment and new state performance measures have been important activities supported through SSDI.//2012//
/2013/ SSDI grant funding was reduced for the current fiscal year, which will likely impact the state's ability to complete all of the identified goals, objectives, and activities.//2013//

Children with Special Health Care Needs Service System -- CSHS supports initiatives that lead to a community-based system of services for all families, children, and youth with special health-care needs. State-level CSHCN staff participate on numerous committees, advisory boards, and task forces and actively work on a variety of special projects to improve children's health. Many of the activities focus on screening, transition, medical home, family partnership and satisfaction, adequate insurance, and community-based service systems. Examples of two of these special projects follow:

First Sounds - ND's Early Hearing Detection and Intervention (EHDI) Program is administered by the ND Center for Persons with Disabilities (NDCPD) at Minot State University. Historically, NDCPD has been an important partner to the state CSHCN program, one that is successful in securing grant funding and supporting collaborative projects that improve the lives of individuals with disabilities. Over time, significant gains have been made in the percent of newborns in ND that have had their hearing screened before hospital discharge. Current grant efforts focus on reducing babies lost to follow-up as well as tracking, surveillance, and integration activities. The EHDI program through NDCPD is funded by MCHB and CDC grants; however, during the 2009 Legislative Session, the Health Department also received $50,000 in general funds to support EHDI-related enhancements. More information about ND's EHDI Program is available at: http://ndcpd.misu.nodak.edu/1stsounds/
/2012/ A three-year MCHB grant was awarded April 2011. The EHDI program has also applied for a five-year CDC data linkage grant.//2012//
/2013/ ND EHDI is currently funded with a three-year MCHB grant which ends March 2014 and a five-year CDC grant which ends June 2016. A 10 percent reduction was received in the second year MCHB grant award. ND will start a National Initiative for Children's Healthcare Quality project to improve the system of care for newborns with possible hearing loss summer of 2012.//2013//

North Dakota Integrated Services (NDIS) -- Major advances to enhance the system of care for CSHCN and their families have been initiated through North Dakota's NDIS Project. The NDIS grant is administered by the ND Center for Persons with Disabilities (NDCPD) at Minot State University. State CSHCN staff are members of the NDIS advisory committee and are active

supporters of NDIS goals to develop a network of learning collaboratives, pilot programs, and a comprehensive plan for integrated services. Efforts of this three-year grant focus on medical home, healthy transitions to adult life, and family involvement/cultural competence. More information about NDIS is available at: www.ndcpd.org/ndis/index.shtml
/2012/ Funding for NDIS ends July 2011. NDCPD applied for another three-year grant to continue medical home development and sustainability efforts.//2012//
/2013/ NDCPD did not receive the three-year grant to continue medical home development and sustainability efforts.//2013//

Culturally Competent Care

Our society is becoming more diverse and often this trend is associated with widening health disparities among culturally diverse groups. Given this development, communication interventions that affect health behavior are increasingly important strategies for improving the health of people. In a response to this issue, Dr. Terry Dwelle, SHO, has developed a Culturally Responsive Communication course. This course is intended to develop and expand the skills of public health professionals in designing and delivering culturally responsive health communication.

Health disparities efforts began in the 1990s to coincide with the national emphasis on health. The movement for healthier North Dakotans began with the DoH taking steps that recognized and created strategies to provide awareness of inequities in health and access. Governor John Hoeven, in 2002, declared health to be one of six pillars of his plan for ND. This declaration helped certain groups to take the lead to address health disparities. In the DoH, a disparities work group was formed with membership from three state agencies: the DoH, DHS and the Indian Affairs Commission. The disparities work group mission was to "provide leadership to raise the awareness of and to eliminate health disparities affecting ND citizens." The definition of health disparities the members to which agreed is described in this comprehensive statement that allows the inclusion of additional groups as they are identified: "Health disparities in ND are defined as inequalities in health status, utilization or access due to structural, financial, personal or cultural barriers."

The State Health Disparities Work Group exists to provide leadership in identifying and positively impacting disparities affecting ND citizens. The workgroups vision is "Health equity for all North Dakotans." Additionally, the DoH and the Indian Affairs Commission, along with tribal leaders through the state, have formed the Tribal State Health Care Task Force in an ongoing effort to address the health care needs of American Indians.

The director for the Office on the Elimination of Health Disparities is a member of many Title V alliances/committees/coalitions/task forces. Title V advisory councils also include members that represent major cultural groups in the state. A stronger connection with the Indian Affairs Commission has been established over the last year. Staff members from the Indian Affairs Commission are active members on the Oral Health Coalition and the Teen Sexuality Stakeholders Group.

The Teen Sexuality Stakeholders Group is focusing their activities on American Indian communities to identify needs for behavioral interventions to improve sexual health for youth. To accomplish this, training sessions on tribal reservations presented by American Indian persons have been arranged for the stakeholder members.

The need to increase and enhance relationships with disparate populations is evident by the fact that the needs assessment process identified "form and strengthen partnerships with families, American Indians and underrepresented populations" as a priority need. Data collected, reported and analyzed for the needs assessment according to race and ethnicity assisted in this prioritization.

/2013/ As a quality improvement project, the DoH will facilitate discussions to identify strengths and weaknesses in their ability to conduct public health programs with tribes. Participating members will include key stakeholders from the DoH, along with the Indian Affairs Commission and the NDSU Director of the Master of Public Health Program. The meetings are scheduled for summer 2012.//2013//
An attachment is included in this section. IIIB - Agency Capacity

C. Organizational Structure

The North Dakota Department of Health (DoH) employs about 350 people dedicated to making North Dakota a healthier place to live. The seven sections of the department include: 1) Administrative Support, 2) Community Health, 3) Emergency Preparedness and Response, 4) Environmental Health, 5) Health Resources, 6) Medical Services, and 7) Special Populations. Employees in these sections provide public health services that benefit the citizens of North Dakota.

The mission of the DoH is to protect and enhance the health and safety of all North Dakotans and the environment in which we live. To accomplish our mission, the DoH is committed to improving the health status of the people of North Dakota, improving access to and delivery of quality health care, preserving and improving the quality of the environment, promoting a state of emergency readiness and response, and achieving strategic outcomes within available resources.
The DoH values include:
• Excellence in providing services to the citizens of North Dakota.
• Credibility in providing accurate information and appropriate services.
• Respect for our employees, our coworkers, our stakeholders and the public.
• Creativity in developing solutions to address our strategic initiatives.
• Efficiency and effectiveness in achieving strategic outcomes.

Terry Dwelle, M.D., State Health Officer is responsible for the administration of programs carried out with allotments made to the state by Title V. The governor appoints the Health Officer. A State Health Council serves as the DoH's advisory body. The council's 11 members are appointed by the governor for three-year terms. Four members are appointed from the health-care provider community, five from the public sector, one from the energy industry and one from the manufacturing and processing industry.
/2013/ As a result of new membership on the State Health Council, the February 2012 meeting was dedicated to learn more about programs and services within the DoH. All Title V programs and services were included in the overview.//2013//

The organizational chart for the DoH can be accessed at the following URL: http://www.ndhealth.gov/DoH/Overview/ (also included in the attached PDF).

The Division of Family Health, within the Community Health Section (CHS) of the DoH, is the lead division for administration of the Title V funds. The CHS is responsible for the public health of all citizens from birth to death. The section's goal is to promote health and prevent illness and disease.
The CHS supports families and communities working to improve the health and safety of North Dakotans by providing education and services, advocating healthy behaviors, assuring quality programs, developing policies, and engaging in statewide partnerships.

There are five divisions within the Community Health Section: 1) Cancer Prevention and Control, 2) Chronic Disease, 3) Family Health, 4) Injury Prevention and Control, and 5) Nutrition and Physical Activity. Three of these five divisions receive funds from the Title V grant. These include Family Health (Title V leadership), Injury Prevention and Control, and Nutrition and Physical Activity.
/2012/ The Community Health Section Leadership Team has started strategic planning as a result of federal reductions and the creation of the Coordinated Chronic Disease Prevention and Health

Promotion Program Grant. This initiative targets heart disease, cancer, stroke, diabetes and arthritis.//2012//
/2013/ A Coordinated Chronic Disease Grant Management Team (MT) has been formed to provide strategic direction. The Title V director is an active participate on the MT. Internally, the Oral Health and the Coordinated School Health Programs have been included as additional targeted initiatives. CSHCN program staff are also involved in the partnership.//2013//

The organizational chart for the Community Health Section can be accessed at the following URL http://www.ndhealth.gov/familyhealth/grantees/fy2013/CHSOrganizationalChart.pdf (also included in the attached PDF).

The CHS has implemented a collaboration project that involves yearly retreats and the selection of topic areas that is of benefit to multiple, if not all, programs within the section and directly benefits Title V activities. Currently, there are six workgroups: Coalition Toolkit, Community Engagement, Grants Efficiency, Marketing, Professional Development and Technology. The Coalition Tool Kit workgroup developed an on-line tool kit for working with coalitions. The Community Engagement workgroup is in the beginning phase to identity priorities. The Grants Efficiency workgroup is developing common language for ND data that all programs can use for grant writing (i.e., State Overview). The Marketing workgroup developed a division fact sheet template so that all division fact sheets are connected by a common look and theme. In addition, a new organizational chart with active links to the section and divisions has been created. The Professional Development workgroup is developing a survey to determine the educational needs of the section. The Technology workgroup developed and sent out several surveys to determine technology needs within the section and provided education sessions (i.e. Share Point, Web Casts, Survey Monkey).
/2012/ The Technology Workgroup continues to be active. A presentation regarding the use of Audience Response Systems is planned for September 2011. //2012//
/2013/ In large part, collaborative efforts within the CHS are now being addressed through Coordinated Chronic Disease Grant projects.//2013//

North Dakota's public health system is made up of 28 single- and multi-county local public health units (LPHUs). LPHUs are autonomous and not part of the DoH. Their relationship is cooperative and contractual. Services offered by each public health unit vary, but all health units provide services in the areas of maternal and child health, health promotion and education, and disease prevention and control. Some local public health units maintain environmental health programs; others partner with the DoH to provide environmental services such as public water system inspections, nuisance and hazard abatement and food service inspections. Local public health activities are financed by a combination of mill levy funding and/or city or county general funds, state aid and federal funding. A state map for each LPHU can be accessed at the following URL http://www.health.state.nd.us/localhd/
/2013/ Local Public Health Units across North Dakota have worked collaboratively together for many years. In August 2010, this relationship was formalized through a Joint Powers Agreement to form the ND State Association of City and County Health Officials (SACCHO), a state association for ND Local Public Health Units. SACCHOs have been formed in many states across the nation to streamline communication between state and local public health agencies, and to stay apprised of national public health initiatives such as continuous quality improvement and public health accreditation. The purpose of ND SACCHO is to improve coordination of local public health department efforts across the state, enhance consistent messaging and education, improve training and advocacy and share best practices. ND SACCHO is governed by a ten member Executive Committee with representatives from local public health units, the State Health Department and the North Dakota Association of Counties. The Title V director attends the quarterly SACCHO meetings to provide Title V program updates.//2013//

The Children's Special Health Services (CSHS) Division, within the Special Populations Section

of the DoH, is the lead division for administration of Title V funds for CSHCN. CSHS is housed within the Special Populations Section, which is composed of the Division of Children's Special Health Services, the Primary Care Office, and the Office for the Elimination of Health Disparities. The Special Populations Section works to improve access to medical services for individuals and families in ND through 1) assistance to help pay for evaluation and treatment of children with special health-care needs and for support of their families; 2) assessment of inequities in health status and utilization and support of programs that strive to eliminate health disparities; and 3) assistance to communities to plan and sustain high-quality health-care systems, especially in underserved areas.

The organizational chart for the Special Populations Section can be accessed at the following URL http://www.ndhealth.gov/familyhealth/grantees/fy2013/SPOrganizationalChart.pdf (also included in the attached PDF).

Delivery of services to CSHCN also involves a partnership with 53 county social service agencies. County social service offices work cooperatively with the state agency in administering programs. County social services are important local service providers and are often the first point of contact for families. Each county social service office has a designated staff member that provides services for CSHCN's and their families served by CSHS.

A state map and contact information for each county social service office can be accessed at the following URL http://www.nd.gov/dhs/locations/countysocialserv/index.html

The following organizational chart can be found in the attached PDF: State of North Dakota Title V.

See Section III B, Agency Capacity for more information on programs funded by the Federal-State Block Grant Partnership.
An attachment is included in this section. IIIC - Organizational Structure

D. Other MCH Capacity

Terry Dwelle, M.D., State Health Officer (SHO), is responsible for the administration of programs carried out with allotments made to the state by Title V. The SHO is appointed by the governor to be the chief administrative officer of the department as well as a member of the governor's cabinet. The SHO implements state laws governing the department with guidance of the governor and the regulations adopted by the State Health Council. In addition, the SHO is a statutory member of about a dozen boards and commissions. Governor John Hoeven appointed Terry Dwelle, M.D., to the Office of SHO in October 2001. Dr. Dwelle earned his medical degree from St. Louis University School of Medicine. He later received a master's degree in public health and tropical medicine from Tulane University. Dr. Dwelle has worked with the University of North Dakota School of Medicine, the Centers for Disease Control and Prevention and the Indian Health Service.

The Deputy State Health Officer (DSHO), Arvy Smith, assists the SHO in implementing state laws governing the department and serves on several boards and commissions in lieu of the SHO. In addition, the DSHO provides leadership in administrative and support functions for the department. Ms. Smith was appointed as the DSHO in October 2001. She has a master's degree in public administration with a health-care certificate, is a certified public accountant and a certified manager who has 28 years experience in state government.

The Division of Family Health, within the Community Health Section (CHS) of the DoH, is the lead division for administration of the Title V funds. There are five divisions within the CHS: 1) Cancer Prevention and Control, 2) Chronic Disease, 3) Family Health, 4) Injury Prevention and Control, and 5) Nutrition and Physical Activity. Three of these six divisions receive funds from the Title V grant. These include Family Health (Title V leadership), Injury Prevention and Control, and

Nutrition and Physical Activity. Senior level staff within these three divisions include:

Family Health: Kim Senn is the Director for the Division of Family Health. Kim joined the DoH in 2000 as a nurse consultant and became Director of the Division of Family Health in September 2003. Kim earned a bachelor's degree in nursing from Medcenter One College of Nursing. Kim has twenty-five years experience in health care, including acute care, management and public health.
/2012/ Kim has had a name change and is now Kim Mertz.//2012//

Injury Prevention and Control: Mary Dasovick is the Director for the Division of Injury Prevention and Control. Mary joined the DoH in 1994 as a nurse consultant and became Director of the Division of Injury Prevention and Control in September 2003. She graduated from the University of Mary with a bachelor's degree in nursing. Mary has worked as a public health, geriatric and forensic nurse.

Nutrition and Physical Activity: Colleen Pearce is the Director for the Division of Nutrition and Physical Activity. Colleen joined the DoH in 1978 and has worked as the program director of the Special Supplemental Nutrition Program for Women, Infants and Children since 1979. She became the Director of the Division of Nutrition and Physical Activity in September 2003. Colleen earned a bachelor's degree in food and nutrition from ND State University and a master's degree in public health from the University of Minnesota.

The CHS has access to a wide range of administrative support personnel within the section and department. CHS support includes Information Technology, Epidemiology and Grant Management. Department support includes Accounting, Human Resources, Information Technology, Vital Records, Education Technology, Public Information, and Local Public Health. A finance liaison, housed in the Accounting Division, is specifically assigned to work with the Title V grant.

/2012/ A new FTE in 2010 allowed for an epidemiology position shared between MCH and oral health. Gregg Reed was hired in May 2010. Gregg earned a bachelor's degree in microbiology and a master's degree in public health from Idaho State University. His past experience includes President of the Board of Directors for a Community Health Center and performing data analyses and evaluating healthcare polices to improve clinical efficiencies at the Rocky Mountain Diabetes and Osteoporosis Center. //2012//

/2013/ A new FTE allowed the DoH to hire an Internal Auditor. Karol Riedman was hired in September 2010. Karol has been a certified public accountant for 28 years and has experience in auditing, business and tax; non-profit, government and public accounting. The position provides management with assessments and recommendations to improve policies and procedures relating to all levels of activities and transactions, and to improve compliance with all applicable Federal, State and local rules and law, improve fraud and other risk prevention and detection, and improve efficiency and effectiveness of all applicable activities.

Dr. Pickard is a Career Epidemiology Field Officer assigned from the Centers for Disease Control and Prevention (CDC) since 2002. Within the DoH, he is assigned to the Office of the State Health Officer. He supports emergency preparedness, epidemiologic capacity building and epidemiologic consultation agency wide. Dr. Pickard provides support and technical assistance to both the State Systems Development Initiative Coordinator and the Maternal and Child Health epidemiologist.//2013//

Healthy North Dakota (HND) is a statewide initiative whose goal is to improve the health of every North Dakotan by inspiring people to establish personal behaviors and support policies that improve health and reduce the burden of health care costs. Title V programs work closely with HND priorities and initiatives. Melissa Olson was named director of HND in 2003. She has

bachelor's degrees in food and nutrition and corporate and community fitness from ND State University. Melissa has worked in state government since 2000, managing both the school health and tobacco programs.

The Children's Special Health Services (CSHS) Division within the Special Populations Section of the DoH, is the lead division for administration of the Title V funds for CSHCN. The CSHS Division maintains eight full-time staff, seven of which are funded by the MCH Block Grant. Currently, all division staff are centrally located in Bismarck, ND. Senior level staff within the section and division include:

Special Populations Section: John Baird, M.D. joined the DoH as a state medical officer in 2002 and became Chief of the Special Populations Section in 2007. He also serves as health officer for Fargo Cass Public Health and as Cass County coroner. Dr. Baird has been an associate professor in family medicine for the UND School of Medicine and Health Sciences and has worked as a family practice physician at the Family Healthcare Center in Fargo, ND. He earned his medical degree from Washington University, St. Louis, Mo. in 1978.

Children's Special Health Services (CSHS): Tamara Gallup-Millner, RN, MPA is the Director of the CSHS Division, a position she has held since July 2007. Tammy has a Bachelor of Science degree in Nursing from Moorhead State University and a Master's degree in Public Administration from the University of North Dakota. Professional experiences include four years in acute care as a hospital staff nurse and over 25 years of experience within state government, including prior positions as Assistant Clinical Supervisor, Deputy Director, and Unit Director of the State CSHCN program when it was located within the North Dakota Department of Human Services.

CSHS contracts for the services of a part-time Medical Director. Joan Connell, MD, MS, RPh became the CSHS Medical Director on January 1, 2009. A former pharmacist, she obtained her medical degree from the University of Colorado in 1998. Dr. Connell is also the Associate Pediatric Clerkship Director at the University of ND (UND) and works as a pediatrician at the UND Center for Family Medicine in Bismarck, ND. CSHS also benefits from a Medical Advisory Council that meets on an annual basis.

The State Systems Development Initiative (SSDI) Coordinator is currently housed in CSHS although the position serves to enhance Title V data capacity for the entire MCH population. Devaiah Muccatira joined the Health Department in this capacity in April 2006. Devaiah has a Bachelors degree in plant protection and a Masters degree in agricultural entomology. He has had a variety of past work experiences as a research assistant and research associate.

CSHS has access to a wide range of administrative support personnel within the DoH including Accounting, Human Resources, Information Technology, Vital Records, Education Technology, Public Information, and Local Public Health. A finance liaison, housed in the Accounting Division, is specifically assigned to work with the Title V grant.

Parents of special needs children have not been hired within CSHS. However, the Division does support a nine-member Family Advisory Council that meets quarterly. Members are reimbursed mileage, meals and lodging and are paid a $75.00 consultation fee for each meeting they attend. The CSHS Family Advisory Council assures family involvement in policy, program development, professional education, and delivery of family-centered care.
/2012/ The CSHS Family Advisory Council currently has ten members and meets two to four times each year.//2012//

Attached is a summary of the Title V/MCH workforce.
An attachment is included in this section. IIID - Other MCH Capacity

E. State Agency Coordination

ND has a long history of interagency coordination and collaboration. Maternal and Child Health (MCH) program staff work with other state agency staff on a daily basis through numerous coalitions, task forces, advisory groups, committees and cooperative agreements.

Organizational Relationships among the State Human Services Agencies

Public Health

MCH program staff work closely with the state local health liaison, who acts as the liaison between the ND Department of Health (DoH) and local public health units and other key public and private partners. In addition, the public health liaison assists in the facilitation of the quarterly local public health administrators' and director of nursing meetings. MCH program staff attends these quarterly meetings as appropriate to solicit program input and to provide program updates.

The state MCH Nurse Consultant works with local public health staff on a regular basis to continually update the Child Health Services Manual. This manual provides guidance to local public health agencies on such topics as immunizations, pediatric assessment, anticipatory guidance, newborn home visits, etc.

Mental Health

The Children's Mental Health System of Care in ND provides therapeutic and supportive services to children with serious emotional disturbance and their families so they can manage their illness and live in the community in the least restrictive setting. The administrator for children's mental health services was invited to the Title V planning retreat. Mental health and social emotional development is also one of the components collaboratively addressed through the state's Early Childhood Comprehensive Systems Grant Program. In addition, mental health/substance abuse was identified as a Healthy North Dakota (HND) priority.
/2012/ The CSHS Division Director is a member of the ND Transition-Aged Youth At-Risk State Advisory Council, which is led by the Children's Mental Health Administrator in the DHS.//2012//

Social Services/Child Welfare

County social service offices are often the first point of contact for families who need economic assistance, child welfare services, supportive services for elderly and disabled individuals, children's special health services, or help locating other local resources and programs. DHS divisions have oversight responsibility for most County Social Service programs. In the DoH, the state CSHCN program has oversight responsibility for programs administered through CSHS.

The Children and Family Division Director is part of the DHS Senior Management team. Programs in that division include: adoption, early childhood services, the child protection program, children's mental health services, family preservation services, foster care services, the head start state collaboration project, and refugee services. Program administrators housed within the Children and Family Division participated in the Title V planning retreat and staff from both areas participate together on various committees.

Education

Title V and the Department of Public Instruction (DPI) have a strong partnership and work collaboratively on many projects.

The CSHCN Director is a member of the state Interagency Coordinating Council, which meets jointly with the DPI Individuals with Disabilities Education Act advisory group on a quarterly basis to better coordinate services for young children with disabilities.

ND received second round funding for the Coordinated School Health Programs (CSHP) and

Reduction of Chronic Diseases Infrastructure Agreement from CDC in March 2008. Please refer to Section B., Agency Capacity.

The ND Center for Persons with Disabilities, at Minot State University, worked with the DoH, DHS, DPI, school nurses and school personnel on the development of a School Health Service Guideline Manual. Targeted for completion by September 2010, this manual will include preventative services, educational services, emergency care, screening recommendations, referrals, and management of acute and chronic health conditions.
/2012/ The Health Guidelines for North Dakota Schools and Emergency Guidelines for ND Schools were distributed in April 2011 to every school building and local public health entity in the state. Child care and Head Start health consultants also received the manual.//2012//

The ND DoH and DPI work together to administer the Youth Risk Behavior Survey (YRBS), Youth Tobacco Survey (YTS) and Profiles. The primary staffing source and lead role for the YRBS and Profiles is DPI. The DoH's epidemiologists serve in advisory roles and provide technical assistance for the surveys.
/2013/ The 2011 YRBS results will be presented at a September 2012 School Health Interagency Workgroup (SHIW) meeting. A speaker from the ND Leadership & Education Administration Development agency will also be discussing how the data can be used to improve children's behaviors.//2013//

In an effort to improve sexual health for youth, a stakeholders group has been formed with representation from the DoH (Family Planning, HIV/AIDS, Office for the Elimination of Health Disparities), the Department of Public Instruction's (DPI) HIV program and the Indian Affairs Commission. In the fall 2009, an application was submitted and approved for technical assistance through the National Stakeholders Collaborative (NSC). NSC is represented by the Association of Maternal and Child Health Programs (AMCHP), the National Alliance of State and Territorial AIDS Directors (NASTAD), the National Coalition of STD Directors (NCSD) and the Society of State Directors for Health, Physical Education and Recreation (SSDHPER). A facilitated meeting by the NSC was held in April 2010 to determine priorities. Collaborating with American Indian communities to identify needs for behavioral interventions to improve sexual health was identified as the top priority. Meetings are planned to occur in July and August 2010 with key tribal representatives to begin discussions. A $5,000 grant opportunity has been submitted through NSC to assist with planning and/or intervention activities.
/2012/ Tell it to Me Straight dinners were held in February 2011. An American Indian Summit focusing on adolescent sexual health was held March 2011. A $5,000 grant was received through NSC to assist with these activities.//2012//

Medicaid

The state Medicaid program is co-located with SCHIP in the Medical Services Division within DHS. The Division Director is part of the DHS Senior Management team. The State Health Officer is a member of the Medicaid Medical Advisory Committee. The state CSHCN program has close ties to Medicaid and participates regularly in scheduled meetings to discuss administrative, claims policy, claims payment, and Medicaid Management Information System (MMIS) issues. CSHS uses MMIS to pay claims for eligible children.

In addition, a cooperative agreement to assure care and improve health status is in place between DHS, DoH, the Primary Care Office, and the Primary Care Association, although Title V leadership acknowledges it needs to be updated.

SCHIP

The SCHIP program is co-located with state Medicaid program in the Medical Services Division within DHS. The Division Director is part of the DHS Senior Management team. Title V staff keep in close contact with the SCHIP Director and staff through committee work, information and

referral activities, and other outreach efforts.

The Legislature appropriated $650,000 during the 2009-2011 biennium for SCHIP outreach. This funding was contracted to Dakota Medical Foundation. Major activities have included a successful Back-to-School Campaign and Media blitzes on behalf of the SCHIP program, which is recent months has seen a gradual increase in enrollment.
/2012/ During the 2011 legislative session, general funds were appropriated for continued outreach. The Dakota Medical Foundation was contracted with to continue these efforts. The Title V director has been invited to participate in the annual SCHIP meeting July 2011.//2012//
/2013/ Title V staff participated in the annual Healthy Steps stakeholders meeting held June 2012. An update of outreach campaign activities was provided, including efforts targeted to American Indian children and families. Suggestions for improvement were also solicited from meeting participants.//2013//

Social Security Administration/Disability Determination Services

Annually, the State CSHCN program convenes a meeting between Disability Determination Services (DDS), the local Social Security Administration office, Medicaid and key family organizations in the state to assure communication about any new developments that have occurred or that are expected during the year that might affect SSI eligible children. Procedures are in place between DDS and CSHS to assure SSI recipients and cessations receive information about program benefits or services. DDS is located in the Disability Services Division. The Division Director is part of the DHS Senior Management team.

Vocational Rehabilitation

Vocational Rehabilitation is co-located with Developmental Disabilities in the Disability Services Division. The Disability Services Division Director is part of the DHS Senior Management team. Title V interacts with Vocational Rehabilitation through membership in the Transition Community of Practice, a group that focuses on transition services for students with disabilities. Additional opportunities to network with Vocational Rehabilitation partners occur as part of transition-related work through the Integrated Services Grant.

Alcohol and Substance Abuse

During the 2009 legislative session, $369,000 was appropriated to the DoH for the ND Fetal Alcohol Syndrome Center at the University of North Dakota (UND), School of Medicine and Health Sciences. Project goals include 1) Increase the detection rates of prenatal alcohol exposure during pregnancy, 2) Increase rates of documented intervention for women drinking prior to and during pregnancy, and 3) Increase utilization of intervention strategies to decrease recurrence of alcohol exposed pregnancies after the birth of an affected child which account for about 20 percent of Fetal Alcohol Spectrum Disorder (FASD) cases. To date, the project has been very successful in working with prenatal health care providers/clinics to implement effective evaluation tools and intervention strategies. The Title V director manages the UND contract.
/2012/ During the 2011 legislative session, funding to continue the fetal alcohol syndrome prevention program was appropriated.//2012//

The Mental Health/Substance Abuse Division within the ND DHS collaborates with several MCH programs. Representatives from the Mental Health/Substance Abuse Division were invited to the Title V planning retreat.

The State Systems Development Initiative Coordinator participates in the State Epidemiological Outcomes Workgroup (SEOW), which was initiated in 2006 by the North Dakota Department of Human Services, Division of Mental Health and Substance Abuse Services. The SEOW advisory committee helped collect and analyze data for the publication entitled "Alcohol, Tobacco, and Illicit Drug Consumption and Consequences in North Dakota -- The North Dakota Epidemiological

Profile", which was disseminated March 2007. The state was recently notified that an additional $200,000 in Substance Abuse and Mental Health Services Administration (SAMHSA) grant funding was awarded effective 10/1/2010. Major activities include development of a data-driven website and data agreements with agency partners.

Relationship of State and Local Public Health Agencies

Federally Qualified Health Centers

Please refer to Section A., Overview of the State.

Primary Care Association

The ND Deputy Director for the Community Healthcare Association of the Dakotas is an active member of the Community Health Section Advisory Committee. This advisory committee meets on a quarterly basis and receives MCH program updates and provides input into program activities. In addition, the Deputy Director is an active member of the ND Oral Health Coalition and is a member of the Policy sub-committee.

Tertiary Care Facilities

There are four major health systems in the state that serve CSHCN's and their families. The most prominent is located in the southeast quadrant and includes a children's hospital. Many of the pediatric subspecialty physicians practice in that same community. A recent merger between Sanford Health out of Sioux Falls, SD and MeritCare in Fargo, ND is expected to build a strong regional health care system whose footprint stretches from eastern and central ND to eastern SD, western MN and part of Iowa and Nebraska. This new infrastructure is expected to improve physician and specialist recruitment and retention efforts and lead to improved health care offerings.

Several physicians participate on committees that have been formed to address Title V priorities. Examples include newborn screening, obesity, etc. The CSHS Medical Advisory Council includes representation of various specialists serving CSHCN's and their families from health systems across the state.

Technical Resources

Title V programs have benefited from the technical resources of the ND Center for Persons with Disabilities (NDCPD) through Minot State University. First Sounds, ND's early hearing, detection, and intervention program is housed at NDCPD. A cooperative agreement is in place between CSHS and the NDCPD that guides EHDI detection, intervention, tracking, surveillance, and integration activities.

In recent years, NDCPD has worked cooperatively with the State CSHCN program and the Utah Leadership Education in Neurodevelopmental Disabilities Regional Program.

The NDCPD at Minot State University in collaboration with the ND DoH and the UND Center for Rural Health was funded for a five-year State Implementation Project for Preventing Secondary Conditions and Promoting the Health of People with Disabilities. North Dakota's "Disability Health Project" promotes the health and wellness of ND citizens with disabilities, and prevents or lessens the effects of secondary conditions associated with disabilities. Title V staff participate on the Disability Health Project Advisory Committee.

The NDCPD at Minot State University received a state implementation grant for Integrated Community Systems for Children and Youth with Special Health Care Needs for the period June 1, 2008 through May 31, 2011. North Dakota's Integrated Services Project focuses on medical

home, family involvement/cultural competence, and healthy transitions. Major objectives address learning collaboratives, pilot programs, and systemic implementation of an integrated services system for children and youth with special health care needs. Title V staff are active participants of the NDIS Advisory Committee and routinely attend learning collaborative and stakeholder planning events.
/2012/ NDIS funding ends July 2011. NDCPD applied for a new HRSA grant that is intended to fund innovative evidence-based models for improving the system of services for CYSHCN's. ND's application focused on medical home development, enhancement, and sustainability.//2012//
/2013/ HRSA grant funding to improve the system of services for CYSHCN was not awarded. However, NDCPD staff created and disseminated a publication titled Medical Home Certification for Providers Serving Children and Youth with Special Health Care Needs, which can be found at: www.ndcpd.org/ndis.//2013//

The NDCPD at Minot State University received special Congressional Initiative funding for autism. The Great Plains Autism Spectrum Disorders Treatment Program (GPAST) provides training, research, and diagnostic and treatment services to North Dakota children and youth suspected or diagnosed with Autism Spectrum Disorders. NDCPD has provided leadership in Autism "Act Early" and State Planning Workgroups, both of which include CSHS staff representation.
/2012/ In an effort to respond to needs identified in the Autism State Plan which was developed by the State ASD Task Force, NDCPD recently applied for a State Implementation Grant for ASD Services.//2012//
/2013/ NDCPD received a three-year Support Autism in ND grant award, which addressed needs identified by the State ASD Task Force. CSHS staff are collaborating partners in this grant initiative and participate on the State Task Force.//2013//

The state CSHCN program and some of the state's universities have developed a mutually beneficial relationship that involves multidisciplinary clinics for CSHCN. These services are often used as a means of pre-service training for nursing, speech, and medical students. The state CSHCN program also benefits from the expertise of faculty who participate as clinic team members. Contracts are in place with Minot State University for two such multidisciplinary clinics. A collaborative relationship also exists with the Speech, Language, and Hearing Clinic at the University of North Dakota.

Title V has also greatly benefited from the technical resources of the ND State Data Center (NDSDC) at ND State University (NDSU). The NDSDC serves as the program evaluation specialist for both the Early Childhood Comprehensive Systems Initiative and the Oral Health Program. The NDSDC also provided expertise to the Title V Needs Assessment process. In addition, the NDSDC has been contracted with to assist with the Maternal, Infant and Early Childhood Home Visiting Program's Needs Assessment requirement.
/2012/ A contract is in place with the NDSDC to assist with the development of fact sheets addressing each of the state's new performance measures.//2012//
/2013/ Title V fact sheets relating to each of the state's 10 priorities/performance measures have been developed and disseminated.

The ND State Data Center, previously housed at NDSU, has transitioned to the ND Department of Commerce.

The Title V director is a member of the ND Compass Advisory Committee. Led by NDSU, ND Compass is a web-based statewide social indicators site that will provide data across a broad spectrum of important issues. The ND Compass website is scheduled to be available later in 2012.//2013//

The Title V Director serves on the MCH Advisory Committee for the Center for Leadership Education in Maternal and Child Public Health at the University of Minnesota's School of Public Health. This advisory committee meets as needed to discuss the master's of public health training

program, continuing education events and outreach activities to the upper Midwest. As requested, the Title V Director also provides input/comments for Healthy Generations, a nationally distributed newsletter by the School of Public Health. In addition, the Title V Director participates in the quarterly Rocky Mountain Public Health Education Consortium conference calls.

The Center for Rural Health at the University of North Dakota (UND) identifies and researches rural health issues, analyzes health policy, strengthens local capabilities, develops community-based alternatives, and advocates for rural concerns. Partnerships with Title V programs and other related programs have resulted in valuable resources/publications such as The Environmental Scan of Health and Health Care in North Dakota. This environmental scan was conducted from December 2008 to February 2009. The report provides an overview of selected health and health care issues in ND. The information presented in the environmental scan is meant to be used by a variety of stakeholders to support efforts to improve health and access to high quality healthcare services, as well as enhance practical knowledge and collaboration. This document was used a resource/reference for our Title V Needs Assessment.

/2013/ A Master of Public Health program is being offered by NDSU and UND starting fall 2012. The University of Mary and United Tribes Technical College are exploring offering a Public Health Certificate Program. The State Health Officer has been an instrumental part of these initiatives.//2013//

Plan for Title V Coordination

Early Periodic Screening, Diagnosis, and Treatment Program (EPSDT)

Located in the ND DHS, the EPSDT Coordinator participated in the Title V planning retreat. In addition, she participates in numerous Title V program workgroups/coalitions such as the Early Childhood Comprehensive Systems Workgroup, the Oral Health Coalition and the Claims Policy meetings within the DHS Medical Services Division. EPSDT holds annual trainings and contacts the Title V Director prior to the training for content input. She also provides input and updates to the EPSDT section of the MCH Children's Health Services Manual.
/2013/ The Health Tracks (formally EPSDT) director has been engaged with the Bright Futures training initiative scheduled for fall 2012.//2013//

Other Federal Grant Programs

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) provides healthy foods for proper growth and development, education on choosing healthier ways of eating, breastfeeding promotion and support and referrals to other needed services. WIC is for eligible pregnant, breastfeeding and postpartum women, infants, and children under five years and is available in all counties in ND. An average of 13,600 mothers and children are seen each month in over 70 WIC clinic sites across the state.
/2012/ An average of 13,500 mothers and children are seen each month in 75 WIC clinic sites across the state.//2012//

WIC has an agreement with the Commodity Supplemental Food Program within the ND Department of Public Instruction. The agreement identifies individuals who are not being served by either program and strengthens relationships between programs to increase accessibility and provide enhanced program coordination. WIC also has a contract with North Dakota State University Extension for the Food and Nutrition Program (FNP) and the Supplemental Nutrition Assistance Program (SNAP). Since many WIC participants are also eligible to receive benefits from these programs, staff work together to provide complementary education and to update each other on projects of mutual interest. State and local WIC staff work closely with several of the MCH programs and HND Committees to further nutrition and/or physical activity related issues.

The state CSHCN program works most closely with the Developmental Disabilities Unit in the area of early intervention. State CSHCN staff participates on the state Interagency Coordinating Council (ICC), a group appointed by the Governor to provide leadership to support improvements in the early intervention system for infants and toddlers with disabilities. Regional ICCs have also been created in eight regions of the state.

Title V also works collaboratively with Developmental Disabilities and other DoH programs to implement the Birth Review Program. This program provides new parents with information on normal growth and development and helps them identify whether possible risk factors are present that may affect their child's development. Concerned parents receive additional information upon request and are linked to various ND service agencies.

Partnerships that address individuals with disabilities across the lifespan have been strengthened with CSHS membership on the State Council on Developmental Disabilities.

The Family Planning Program offers education, counseling, exams, lab testing, infertility services and contraceptives. Please refer to Section B., Agency Capacity.

Pregnant Women and Infants

The Optimal Pregnancy Outcome Program (OPOP) provides multi-disciplinary teams committed to enhance the prenatal care women receive from their primary health care provider. Please refer to Section B., Agency Capacity.

The Tobacco Partnership is a group of individuals representing the programs of Family Planning, SIDS, Tobacco, OPOP and WIC. The goal of this partnership is to strategize avenues to prevent and/or reduce the use of tobacco by women of reproductive age. Data collection, analysis and dissemination to increase public knowledge are key objectives of the group.
/2012/ The Tobacco Partnership developed a safe sleep media campaign focusing on secondhand smoke and its increased risk to SIDS. Television, radio and print ads were created. The campaign started in April 2011 and will continue throughout the year.//2012//

Title V staff actively collaborate with a variety of state and local programs that target interventions and/or deliver services to pregnant women and infants such as the Department of Human Services, Division of Children and Family Services; March of Dimes; Prevent Child Abuse ND; and Child Care Resource and Referral.
/2013/ Title V staff and the March of Dimes (MOD) have formed a partnership to improve infant health outcomes. Joint PSA's and press releases are being planned around the MOD's "Healthy Babies are Worth the Wait" public awareness campaign. The State Health Officer signed the Association of State and Territorial Health Officers (ASTHO) and MOD pledge to reduce infant mortality. The Title V director has been named as the contact person for the initiative.//2013//

Family Leadership and Support Programs

There are three primary family-led organizations in ND that provide leadership and support to families. They include Family Voices (health information, training, and parent-to-parent support for CSHCN), Pathfinder Family Center (education), and the Federation of Families (mental health). The state CSHCN program contracts with Family Voices to provide emotional support, health information, and training for families in the state and has a representative on the Family Voices board. Family Voices has strengthened its infrastructure and ability to mobilize communities through regional staff and the development of Parent Navigator Teams.
/2012/ A Hands & Voices Chapter is forming to support families and individuals in the deaf and hard of hearing community.//2012//
/2013/ Family Voices of ND will be sponsoring The ND Summit on Causal Leadership October 2012. This summit will bring together key stakeholders to discuss a growing

paradigm shift for partnering with families. The ECCS Program director has been actively involved in the planning process and ECCS funds are being used to support the summit.//2013//

Family support is also provided through various programs that serve CSHCN's and their families. For example, CSHS supports a nine member Family Advisory Council to assure family involvement in policy, program development, professional education, and delivery of care. Families participate on many other Title V led committees.
/2012/ The CSHS Family Advisory Council now consists of ten members.//2012//

A State Family Liaison Project was initiated March 2008 by the Department of Human Services. Work activities of project staff include increasing awareness of family issues and providing technical assistance and training to regional and tribal experienced parents involved in the state's early intervention system. Experienced parents have also been hired as staff at many of the state's regional Human Service Centers to help families who have young children with disabilities.

The ND Center for Persons with Disabilities at Minot State University received a three-year HRSA grant to develop a Rural Health Network for Family Support for the period May 1, 2008 through April 30, 2011. FamNet, as the network is known, assists rural ND families and providers to improve the health and well being of children with special health care needs through enhanced family support services. Efforts focusing on development of a self-sustaining network have included gaining a Certificate of Incorporation through the ND Secretary of State effective 11/24/2009. A CSHS staff person is a member of the FamNet board.
/2012/ April 2011, ND FamNet was determined to be a public charity and received tax exempt status under section 501(c)(3) of the Internal Revenue Code.//2012//
An attachment is included in this section. IIIE - State Agency Coordination

F. Health Systems Capacity Indicators

/2013/ All Health System Capacity Indicators (HSCI) were considered relevant for discussion by ND's Title V program.

The State Systems Development Initiative (SSDI) Coordinator collects the data for all of the HSCIs. The SSDI initiative supports the Maternal and Child Health program in accessing relevant information for program monitoring/evaluation and policy development.

#01. The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -- 493.9) per 10,000 children less than five years of age.

The source for this data is the ND Department of Human Services, Medical Services Division. The rate of children less than five years of age hospitalized for asthma has decreased from calendar year 2007 to calendar year 2010. Rates that were determined using Medicaid claims data were 11.5 in CY 07, 8.7 in CY 08, 5.4 in CY 09 and 5.0 in CY 10. Starting in 2007, a three-year rolling average was used to reduce variability because of small numbers.

Despite the absence of a currently functioning State Asthma Workgroup, asthma-related information is maintained on the ND Department of Health's (DoH) website (http://www.ndhealth.gov/asthma). A ND asthma action plan is also available.

Children's Special Health Services (CSHS) and other partners support activities to diagnose and treat asthma according to national standards. Activities have included the following:

• CSHS staff developed a Resource Booklet for children with asthma (http://www.ndhealth.gov/cshs/resourcebooklets.htm).

• For several years, Spirit Lake Nation has held an asthma clinic at Fort Totten, ND.

• Since 2003, CSHS has provided funding for a multidisciplinary Regional Children's Asthma Clinic that serves individuals living in the southwestern region of the state.

• Since October 2007, Medicaid has contracted with a vendor to implement a chronic disease management program called ExperienceHealth ND. Asthma is one of the four conditions included in this well-utilized program.

• Blue Cross Blue Shield of ND initiated a MediQHome quality program. Asthma is one of the diseases tracked to monitor achievement of desired clinical outcomes.

Policy changes supported by the DoH and community coalitions have established tobacco-free environments that have the potential to impact this measure. It is anticipated that current programmatic efforts will be continued.

#02. The percent of Medicaid enrollees whose age is less than one year who received at least one initial periodic screen.

The source for this data is the ND Department of Human Services, Medical Services Division, Health Tracks Program. In 2001, the percent of Medicaid enrollees less than one year of age that received at least one initial periodic screen was 55.1 percent compared to 71.2 percent in 2010. Over the last five years, this number has fluctuated ranging from 70.3 to 87.8 percent, with an average of 77.2 percent.

All new Medicaid recipients receive information regarding Health Tracks (formerly EPSDT) services from their eligibility caseworker. Participants in the Temporary Assistance for Needy Families program also receive an incentive for completing an annual periodic screen. Title V funded staff at the state and local level encourage all Medicaid eligible children to complete an annual Health Tracks screen and promote use of medical home providers.

In addition to information and referral services, Children's Special Health Services (CSHS) actively links families to Medicaid. CSHS requires all new applicants for the Specialty Care Program be screened for Medicaid eligibility prior to determining eligibility for CSHS. In addition, an annual outreach mailing is conducted to families with uninsured children to provide information regarding a variety of available health care coverage programs.

The Optimal Pregnancy Outcome Program and ND Family Planning programs have systems in place to screen all clients for Medicaid eligibility and to make referrals to Health Tracks.

Medicaid-eligible children began receiving continuous eligibility for one year effective June 1, 2008. Prior to that date, the child's eligibility had to be determined each month, which caused some children to fluctuate on and off the program depending on the family's income for the month. Based on annual Health Tracks participation reports, the number of individuals eligible has increased since continuous eligibility went into effect.

Title V will promote Bright Futures Guidelines for Health Supervision in order to impact this measure. It is anticipated that current programmatic efforts also will be continued.

For additional information, refer to Part Two, Section III., E. State Coordination for activities related to Early Periodic Screening Diagnosis and Treatment Program.

#03. The percent of State Children's Health Insurance Program (CHIP) enrollees whose age is less than one year who received at least one periodic screen.

The source for this data is a special report generated by Blue Cross Blue Shield of ND. The percent of infants less than one year that received a periodic screen decreased from 82.6 percent in 2005 to 81.0 percent in 2010. In 2006 this percentage dropped to 75.6 percent but since that time has gradually been increasing. Over the last five years, the percent of enrollees that received a screening averaged 78 percent. Over the last five years, the number of infants enrolled in Healthy Steps, the Children's Health Insurance Program (CHIP). has averaged 110 enrollees less than one year of age. This number has decreased, the result of which may be attributed to the implementation of 12-month continuous eligibility for ND Medicaid that went into effect mid-June of 2008.

The Department of Human Services (DHS) is responsible for staffing the 1-877 KIDS NOW Helpline that connects families to information, assistance, and applications for three low-cost/free health coverage programs. A combined application and streamlined enrollment process for Medicaid, CHIP and Caring for Children programs has kept many children from falling through the cracks. The 2009 legislature approved the expansion of CHIP to 160 percent net income effective July 1, 2009. The 2011 legislative session maintained eligibility at 160 percent net income and provided funding for outreach. As a result of the outreach funding, DHS has contracted for a media campaign, which includes special outreach to the Native American population and distribution of materials through birthing hospitals.

Title V funded staff at the state and local level provide information and referral services to the Healthy Steps program for families with uninsured children and encourage establishment of a medical home and well-child follow-up according to endorsed pediatric periodicity schedules. CSHS actively links families to CHIP by requiring that all new uninsured applicants for the Specialty Care Program be referred to the Healthy Steps program when determining eligibility for services.

Prior to the initiation of 12-month continuous eligibility for Medicaid, some children accessed CHIP for the months they were not eligible for the Medicaid program. Now, more children are staying on Medicaid. This shift from CHIP to Medicaid may impact the overall number of CHIP enrollees. At the same time, there is certainly potential to see higher numbers of CHIP-eligible children with the 2009 changes in eligibility levels and the 2011 funding for substantial outreach activities. Whether any of these changes will translate to an increased number of infants receiving at least one periodic screen is unknown.

Title V will promote Bright Futures Guidelines for Health Supervision in order to impact this measure. It is anticipated that current programmatic efforts will also be continued.

Refer to Part Two, Section III., State Overview for program strategies in place to maintain and/or enhance this Indicator.

#04. The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.

In 2010, 83.7 percent of women received adequate prenatal care as measured by the Kotelchuck index, a decrease from 84.1 percent in 2009. This Indicator has historically remained stable with percentages ranging from 82.4 to 88.3 percent.

The March of Dimes 2011 Premature Birth Report Card for ND indicated a rate of 10.6, which results in a grade "B," compared to the nation at 12.2 percent, a grade "C." Selected contributing factors included uninsured women, women smoking, and late preterm birth.

Program strategies in place to maintain and/or enhance this Indicator include: Optimal Pregnancy Outcome Program (OPOP) clinic sites that focus on the importance of prenatal care; Family Planning clinic sites that counsel and refer clients with a positive pregnancy test for pregnancy confirmation; Women, Infant and Children (WIC) clinic sites that screen and refer for prenatal care; and the participation of Maternal and Child Health (MCH) staff on March of Dimes committees.

To assure MCH program staff access to policy and program relevant information related to this Indicator, the following activities have taken place:

1. Upgrade of the OPOP system. The new application enables the state to collect and analyze health information for pregnant women who are at high risk and are very low income.

2. The MCH program continued the partnership with the National Cribs for Kids (CFK) Program to promote safe-sleep education. There are currently 15 CFK partner sites statewide.

3. Title V staff participates on the newly formed Home Visiting Coalition, facilitated by Prevent Child Abuse ND. The Title V director will be providing a letter of support to PCAND for their Maternal, Infant and Early Childhood Home Visiting grant application, which is due July 19, 2012.

The Birth Review Program provides health related service information to new birth families, including those with birth defects, which are the leading cause of infant death in ND. The SSDI Coordinator maintains the ND Birth Defects Monitoring System.

#05. Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State.

5A. Percent of low birth weight (<2,500 grams):

The source for this data is the ND Department of Health, Division of Vital Statistics. There has been little change in this Indicator over the last five years. During this period, the overall percent of low birth weight in ND has ranged from 6.3 percent to 6.8 percent, with an average of 6.6 percent. The percent of low birth weight has consistently been higher for the Medicaid population compared to the non-Medicaid population. In 2010, 6.7 percent of all births were low birth weight (<2,500 grams). Of the 605 low birth weight births, 201 were Medicaid and 404 were non-Medicaid.

Refer to Part Two, Section III., State Overview, HSCI #04 for program strategies in place to maintain and/or enhance this Indicator.

Refer to HSCI #04 for measures to assure that MCH program staff have access to policy and program relevant information related to this Indicator.

5B. Infant Deaths per 1,000 live births:

The source for this data is the ND Department of Health, Division of Vital Statistics. Overall, there is some variability with this Indicator because of the small number of infant deaths. Over the last five years, the overall percent of infant deaths per 1,000 live births has ranged from 4.5 percent to 7.4 percent with an average of 5.7 percent. In 2010, 4.5 percent of all live births resulted in infant death. Of the 41 infant deaths per 1,000 live births in 2010, 18 were Medicaid and 23 were non-Medicaid.

Refer to Part Two, Section III., State Overview, HSCI #04 for program strategies in place to maintain and/or enhance this Indicator.

Refer to HSCI #04 for measures to assure that MCH program staff have access to policy and program relevant information related to this Indicator.

5C. Percent of Infants born to pregnant women receiving prenatal care beginning in the first trimester:

The source for this data is the ND Department of Health, Division of Vital Statistics. Overall, the percent of infants born to pregnant women receiving prenatal care beginning in the first trimester has remained relatively stable. Over the last five years, the overall percent has ranged from 82.3 percent to 84.1 percent, with an average of 83.2 percent. Of the 83.6 percent of infants born to pregnant women receiving prenatal care beginning in the first trimester in CY 2010, women covered by Medicaid were at 72.2 percent while non-Medicaid women were at 88.2 percent. Use of the new US Standard birth record has impacted data related to this indicator, as there are a high number of unknown values for the date of the first prenatal care visit.

Refer to Part Two, Section III., State Overview, HSCI #04 for program strategies in place to maintain and/or enhance this Indicator.

Refer to HSCI #04 for measures to assure that MCH program staff have access to policy and program relevant information related to this Indicator.

5D. Percent of Women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck index]:

The source for this data is the ND Department of Health, Division of Vital Statistics. Over the last five years there has been little variation in the percent of women with adequate prenatal care. The overall percent has ranged from 82.3 percent to 84.1 percent with an average of 83.2 percent. Of the 83.6 percent of women with adequate prenatal care in 2010, the percent of women on Medicaid was 72.2 percent compared to 88.2 percent of non-Medicaid women. Use of the new US Standard birth record has impacted data related to this indicator, as there are a high number of unknown values for the date of the first prenatal care visit.

Refer to Part Two, Section III., State Overview HSCI #04 for program strategies in place to maintain and/or enhance this Indicator.

Refer to HSCI #04 for measures to assure that MCH program staff have access to policy and program relevant information related to this Indicator.

#06. The percent of poverty level for eligibility in the State's Medicaid and CHIP programs for infants (0 to 1), children and pregnant women.

6A. Infants 0-1:

The source for this Medicaid data is the ND Department of Human Services, Medical Services Division. Eligibility levels have remained unchanged for the identified population groups for several years. In 2010, Medicaid eligibility for infants 0 to 1 was at 133 percent net income. CHIP eligibility for infants 0 to 1 was at 160 percent net income. Continuous Medicaid eligibility for pregnant women and children to age 19 went into effect 6/1/2008.

Refer to Part Two, Section IV., National Performance Measures #4 and #13 for program strategies in place to maintain and/or enhance this Indicator.

6B. Medicaid Children:

The source for this Medicaid data is the ND Department of Human Services, Medical Services Division. Eligibility levels have remained unchanged for the identified population groups for several years. In 2010, Medicaid eligibility for children ages 1 to 6 was at 133 percent net income. Medicaid eligibility for children ages 6 to 19 was at 100 percent net income. In 2010, CHIP eligibility for all children ages 1 to 19 was at 160 percent net income. Continuous Medicaid eligibility for pregnant women and children to age 19 went into effect 6/1/2008.

Refer to Part Two, Section IV., National Performance Measures #4 and #13 for program strategies in place to maintain and/or enhance this Indicator.

6C. Pregnant Women:

The source for this Medicaid data is the ND Department of Human Services, Medical Services Division. In 2010, Medicaid eligibility for pregnant women continued at 133 percent net income. CHIP for pregnant women was at 160 percent net income. Continuous Medicaid eligibility for pregnant women and children to age 19 went into effect 6/1/2008.

Refer to Part Two, Section IV., National Performance Measures #4 and #13 for program strategies in place to maintain and/or enhance this Indicator.

#07A. The percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program.

The source for this data is from the ND Department of Human Services, Medical Services Division. Over the last five years, the percent of potentially Medicaid-eligible children who received a service paid by the Medicaid Program has fluctuated somewhat but averaged 87.1 percent. In 2010, 80.0 percent of potentially Medicaid eligible children received a service paid by the Medicaid Program.

Title V funded staff at the state and local level provide information and referral services for families with uninsured children and encourage establishment of a medical home and well-child follow-up according to endorsed pediatric periodicity schedules. Local public health nurses are actively involved in the Health Tracks (formerly EPSDT) screening process.

In addition to information and referral services, CSHS actively links families to public coverage sources by screening for Medicaid when determining eligibility for CSHS and requiring all new uninsured applicants for the Specialty Care Program be referred to the Children's Health Insurance Program (CHIP). An annual outreach mailing listing possible health care coverage options is sent to families that have children with special health care needs (CSHCN's) without current health care coverage. CSHS staff members participate in a variety of Medicaid meetings to influence Medicaid payment and coverage policies for CSHCN's and their families.

The Department of Human Services (DHS) is responsible for staffing the 1-877 KIDS NOW Helpline that connects families to information, assistance and applications for three low-cost/free health coverage programs. A combined application and streamlined enrollment process for Medicaid, CHIP and Caring for Children programs has kept many children from falling through the cracks. The 2009 legislature approved the expansion of CHIP to 160 percent net income effective July 1, 2009. The 2011 legislative session maintained eligibility at 160 percent net income and provided funding for outreach. As a result of the outreach funding, DHS has contracted for a media campaign, which includes special

outreach to the Native American population and distribution of materials through birthing hospitals.

Refer to Part Two, Section III., State Overview, E. State Agency Coordination, Medicaid for program strategies in place to maintain and/or enhance this Indicator.

#07B. The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.

The source for this data is from the ND Department of Human Services, Medical Services Division, Health Tracks program (formerly EPSDT). The percent Health Tracks eligible children ages 6-9 who have received dental services has increased progressively from 28.0 percent in FY 2006 to 49.8 percent in FY 2010. The number of eligible children receiving any dental service in 2010 was 4,298. Legislation involving an increase in Medicaid reimbursement has played an instrumental role in reducing financial barriers and facilitating access to health-care services.

A ND Department of Health program strategy to maintain and enhance this indicator included the dissemination of guidelines developed by recognized dental organizations that recommend children have periodic preventive dental examinations and follow-up services starting at one year of age and thereafter at intervals based on risk assessments.

In 2011, the ND Board of Dental Examiners had a rules change allowing dental hygienists to practice under general supervision. They now have the ability to apply fluoride varnish and/or sealants in public health settings without the direct supervision of a dentist. Building workforce capacity and infrastructure to carry out and implement a school-based dental sealant/varnish program increases oral health preventative behaviors and access to dental care, which ultimately leads to decreased disparities and improved oral health and well-being of children and adults.

In May 2010, the state Oral Health Program received a HRSA Oral Health Workforce grant. Development and implementation of a statewide sealant program and fiscal support for a dental care mobile are included in the workplan activities. The school based sealant program began in the fall of 2011 and currently is targeted at schools with 50 percent or higher free and reduced lunch rates. The ND Ronald McDonald House Charities care mobile has been operational since February 2012. With this grant, dental services to children are expected to increase.

#08. The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs Program."

The numerator is SSI beneficiaries under 16 years old receiving services through CSHS. The source for the denominator is a report from the Social Security Administration (SSA) for children receiving federally administered SSI payments in ND. Over the last five years, the percent of SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs Program ranged from 8.8 to 16.2 percent. In FFY 2010, CSHS served 28.6 percent of SSI beneficiaries less than 16 years old compared to 10.3 percent in FFY 2009. This large increase was due to implementation of a consistent electronic referral system, which was implemented on October 1, 2009.

CSHS convenes an annual meeting with Medicaid, the SSA, Disability Determination Services (DDS), Family Voices and state CSHS program staff to jointly monitor the status of the SSI population and share program updates or developments that have occurred during the year. DDS routinely provides electronic referrals to assure that children served are consistently made known to the Title V program. In response, CSHS conducts outreach activities for the SSI program and provides state-level care coordination for all

DDS referrals that are received, primarily through delivery of information and referral services.

Refer to Part Two, Section III., State Overview, B. Agency Capacity, Services for children with special health care needs.

#09A. The ability of States to assure that the Maternal and Child Health program and Title V agency have access to policy and program relevant information and data.

The States' ability to assure that the MCH program and Title V agency have access to policy and program relevant information and data was maintained at 16 out of 21 possible points. ND continues to lack adequate infrastructure to meet the data needs of the MCH population. The ND State Systems Development Initiative (SSDI) project addresses some of the identified gaps and enhances the collection, analysis, synthesis, reporting, and dissemination of data. In addition, life course performance metrics will be explored to inform Title V planning, evaluation, and policy development. The following goals and objectives are in place through the SSDI:

Goal 1: Enhance data capacity and infrastructure for the MCH population by:
• On an annual basis, assure data linkage and analysis of birth, death, Medicaid, and newborn screening files.
• Enhance the ND Birth Defects Monitoring System Registry.
• Develop and disseminate products to inform MCH programs, policy and practice.

Goal 2: Incorporate life course perspective and metrics into MCH programs, policy and practice by:
• Provide information and education on life course to ND Department of Health staff.
• Monitor development of longitudinal data systems in ND.

Goal 3: Enhance data collection, reporting capacity and needs assessment processes for ND's MCH population by:
• Enhance the Title V MCH five-year needs assessment process.
• Complete data components of the annual Title V MCH Block Grant application.

In addition to the data sources listed in this Indicator, the Title V agency also has access to the following:
• National Survey of Children With Special Health Care Needs
• North Dakota Birth Defects Monitoring System
• Youth Risk Behavior Survey
• Census data from the ND Department of Commerce
• Data from Center for Social Research at North Dakota State University
• Children's Special Health Services (CSHS) program data
• Medicaid Paid Claims and Enrollment data from the ND Department of Human Services
• Vital Record data
• Newborn Metabolic Screening data
• Newborn Hearing Screening data
• WIC data for pregnant women
• National Children's Health Survey
• Behavioral Risk Factor Surveillance System
• Kids Count data
• National Immunization Survey data
• Data from Pediatric and Pregnancy Nutrition Surveillance System
• Data from the Trauma Registry
• Data from the STD MIS System
• Crash Reporting System data from the ND Department of Transportation

Challenges continue with availability of hospital discharge data, a consistent survey of recent mothers (PRAMS-like data), staff time to perform numerous data linkage activities, and recent funding decreases for the SSDI grant, which potentially limit accomplishment of all above identified grant activities.

#09B. The ability of States to determine the percent of adolescents in grades 9 through 12 who report using tobacco products in the past month.

Since 1993, the Youth Risk Behavior Survey (YRBS) has been conducted every two years. The percentage of ND youth who currently smoke cigarettes significantly decreased from 35.3 percent in 2001 to 19.4 percent in 2011. Between 2001 and 2011, the use of smokeless tobacco products among ND youth remained virtually unchanged from 13.2 percent to 13.6 percent. The percentage of individuals who smoked their first whole cigarette before the age of 13 significantly decreased from 25.4 in 2001 to 8.6 in 2011. The percentage of youth in grades nine through twelve who have smoked cigarettes or cigars or used chewing tobacco, snuff, or dip on one or more of the past 30 days, has decreased from 34.1 percent in 2003 to 28.3 percent in 2011.

To assure MCH program staff have access to policy and program relevant information related to this indicator, MCH and tobacco staff are engaged in the School Health Interagency Community Workgroup, which is responsible for YRBS question selection and the development of data reports and dissemination.

Collaboration occurs between the ND Department of Health (DoH), Department of Public Instruction, and other state and local entities to review key tobacco data and determine how needs should be addressed. The DoH Tobacco Prevention and Control Program is preventing and reducing tobacco use by working with tobacco prevention partners, including the Coordinated School Health Program (CSHP) to build and support programs at the state and local levels including schools. In addition, efforts focus on community and cessation programs, statewide public education campaigns and addressing enforcement of state and local tobacco control laws. Statewide leadership and collaboration is needed along with program coordination and evaluation. The DoH Tobacco Prevention and Control Program also works closely with partners to integrate program efforts within chronic disease prevention programs.

Working with youth in populations disparately effected is critical to address higher tobacco use rates. The DoH Tobacco Prevention and Control Program contracts with Boys and Girls Clubs (BGC) of Three Affiliated Tribes on the Fort Berthold Reservation to work on tobacco prevention and control for all people on the reservation. A key strength of the BGC is their culturally-based work with youth grades K-12 that focuses on prevention, primarily tobacco. The DoH Tobacco Prevention and Control Program partnered with the Department of Human Services prevention coordinators to provide training on topics such as comprehensive tobacco policy and NDQuits cessation services to BGC staff who work with youth and their families throughout the Fort Berthold Reservation. The BGC sponsored a Youth Summit focusing on tribal youth. The summit provided culturally relevant commercial tobacco abuse activities to hundreds of reservation youth. These activities not only informed youth, but also allowed them to share their own experiences of loss due to tobacco, as well as learn how traditional tobacco was used by their elders.

Cessation services in ND assist with further decreasing tobacco usage rates and are provided by the DoH's NDQuits program. The program includes telephone counseling provided by the ND Tobacco Quitline along with online cessation services through ND QuitNet. These programs offer counseling services to individuals 14 years of age and older at no cost.

The DoH Tobacco Prevention and Control Program partnered with the ND Center for

Tobacco Prevention and Control Policy to implement a statewide tobacco prevention and control plan. A key strategy involved continued integration of CSHP and Tobacco Prevention and Control Program efforts. In addition, a primary focus in changing social norms surrounding tobacco use was the development of community wide smoke-free policies. At this time, there are eight communities in ND that have smoke-free ordinances stronger than the state law.

The DoH Tobacco Prevention and Control Program has also partnered with the ND School Board Association (NDSBA) to promote the ND Tobacco-Free Comprehensive School Policy. Working together, the DoH and the NDSBA have updated the policy; the NDSBA has adapted the policy as their primary tobacco policy. Currently, 53 of 246 school districts have adopted a comprehensive tobacco-free school policy. This protects 50 percent of ND youth.//2013//

IV. Priorities, Performance and Program Activities

A. Background and Overview

In May 2009, a five-year needs assessment "kick-off" meeting was held for state Title V staff, Department of Health epidemiology partners and the executive director for Family Voices ND, Inc. As a result of this meeting, Title V Needs Assessment process and timelines were established.

In August 2009, a Title V/MCH Needs Assessment Survey was sent out to a variety of partners to gather input on the perceived needs for the three target population groups: pregnant women, mothers and infants to age one; children and adolescents age 1 to 24; and children and youth with special health care needs. A total of 502 responses were received. Results of the survey were shared back to partners via email.

In October and November 2009, nine focus groups were conducted targeting youth ages 14-17 (54 participants); young adults ages 18-24 (43 participants); and parents of children with special health care needs (7 participants). Qualitative data was gathered at each focus group to assess general behaviors of youth and young adults, identify patterns and themes and get suggestions from parents of children with special health care needs on improving existing services or creating new ones. The North Dakota Center for Persons with Disabilities, a University Center of Excellence at Minot State University, was contracted with to conduct the focus groups.

The core Title V planning group spent December 2009 and January 2010 examining and analyzing the results of the stakeholder survey and the focus groups, as well as numerous other pertinent data sources, to develop a data presentation. On February 2, 2010, a planning retreat with 75 key stakeholders was held. Needs assessment data was presented, and with the help of a facilitator, priority needs were identified. Results of the planning retreat were shared with partners via email.

In February and March 2010, the core Title V planning staff refined the identified priorities, developed performance measures and discussed intervention strategies and partner opportunities. The needs assessment process and the resulting 10 priorities/performance measures have been shared with various groups:

• Form and strengthen partnerships with families, American Indians and underrepresented populations.
o Performance Measure 1:
The degree to which families and American Indians participate in Title V program and policy activities.

• Form and strengthen a comprehensive system of age appropriate screening, assessment and treatment for the MCH population.
o Performance Measure 2:
The percent of Medicaid enrollees receiving Early Periodic Screening, Diagnosis and Treatment (EPSDT) screening services.

• Support quality healthcare through medical homes.
o Performance Measure 3:
The percent of children age 0 through 17 receiving health care that meets the American Academy of Pediatrics (AAP) definition of medical home.

• Increase participation in and utilization of family support services and parent education programs.
o Performance Measure 4:
The percent of parents who reported that they usually or always received the specific information they needed from their child's doctor and other health care providers during the past 12 months.

• Increase access to available, appropriate and quality health care for the MCH population.
o Performance Measure 5:
Increase the number of children ages 0 through 2 served by an evidenced-based home visiting program.

• Promote optimal mental health and social-emotional development of the MCH population.
o Performance Measure 6:
Decrease the percent of students who reported feeling so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during the past 12 months.

• Increase the number of child care health consultants and school nurses who provide nursing health services to licensed child care providers and schools.
o Performance Measure 7:
The ratio of students per school nursing FTE.

• Reduce violent behavior committed by or against children, youth, and women.
o Performance Measure 8:
Reduce the percent of students who were bullied on school property during the past 12 months.

• Reduce the rate of deaths resulting from intentional and unintentional injuries among children and adolescents.
o Performance Measure 9:
The rate of deaths to individuals ages 1 through 24 caused by intentional and unintentional injuries per 100,000 individuals.

• Promote healthy eating and physical activity within the MCH population.
o Performance Measure 10:
The percent of healthy weight among adults ages 18-44.

/2013/ Title V staff meet every other month to discuss key strategies and program activities relating to each of the ten priorities/performance measures. Workplan activities for 2013 are focused on collaborative partnerships to accomplish performance measure outcomes.//2013//

B. State Priorities

After the selection of the state's 10 priority needs and development of state-negotiated performance measures, Title V staff meet together to determine the annual plan for both the Federal and State performance measures. In previous years, Maternal and Child Health (MCH) and Children's Special Health Services (CSHS) staff worked separately on the annual plan, each focusing on their areas of expertise. Working together as a Title V staff to plan activities for all performance measures has increased staff's knowledge and collaboration between programs.

Title V staff meet quarterly to receive updates from the Title V and CSHS directors as well as to share program activities. In the upcoming year, the annual plan will be a focus of each meeting to assure continued collaboration and progress.

ND has adequate capacity and resources to address most of the Federal and State performance measures. MCH programs are spread primarily among three divisions within the Community Health Section of the Department of Health (DoH); Family Health, Injury Prevention and Control and Nutrition and Physical Activity. Although the programs has relatively small numbers of staff persons (about 9.5 full time equivalents), MCH has experienced, qualified individuals administering injury prevention, oral health, nutrition, family planning, school health, newborn screening and maternal, infant and early childhood programs. The injury prevention program

coordinates much of the programmatic activity for performance measures related to reduction of mortality and injury. The abstinence and family planning program directors have the responsibility for the measure related to teen birth rate. The newborn screening program director reports on the newborn screening measure. The MCH nutritionist has the responsibility for the breastfeeding measure. The MCH nurse consultant has the responsibility for the measures related to low birth weight and prenatal care.

MCH program staff has little direct impact on the Federal performance measures for childhood immunization, children without health insurance, children receiving a service paid by the Medicaid program, and very low birth weight infants born at facilities for high-risk deliveries. These activities focus on collaboration efforts with other programs and agencies such as the Division of Disease Control in the DoH and the state Medicaid Program within the Department of Human Services (DHS).

CSHS program staff has responsibility for the six federal measures for children with special health care needs (CSHCN) in addition to the measure for newborn hearing screening. For national performance measure #1, CSHS has programmatic responsibility for treatment of eligible individuals with metabolic diseases. CSHS provides metabolic food to eligible individuals with PKU and MSUD.

CSHS has developed program plans to impact the five other national performance measures for CSHCN (family partnership and satisfaction, medical home, insurance, community-based service system organization, and transition). However, the state CSHCN program directly serves only a fraction of all CSHCN in the state, therefore making direct impact on any of the measures difficult.

Title V staff has the resources to carry out activities that are expected to impact each of the state's newly selected priority needs and performance measures. As mentioned above, integrating program activities with all Title V staff is expected to increase progress. However, Capacity Assessment has been identified as an area for technical assistance in the upcoming year. A Capacity Assessment conceptually links program's roles and activities to population health and service systems through a strategic assessment of organization capacity needs. Through a Capacity Assessment, ND's Title V programs hopes to determine what organizational, programmatic and management resources must be developed or enhanced in order to fulfill the program's goals and objectives.

Note: Final 2008 data was used as provisional data for 2009 for all national performance measures, state performance measures, national outcome measures, state outcome measures, health status indicators and for some health system capacity indicators.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	16	18	19	19	19
Denominator	16	18	19	19	19
Data Source		See note field.	See note field.	See note field.	See note field.
Check this box if you cannot report the					

numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	100	100	100	100	100

Notes - 2011
2011-Final 2010 data was used as provisional data for 2011. The source for 2010 data is the Iowa Hygienic Laboratory and North Dakota Department of Health Newborn Screening Program.

Notes - 2010
2010-The source for 2010 data is the Iowa Hygenic Laboratory and North Dakota Department of Health Newborn Screening Program.

Notes - 2009
2009- The source for 2009 data is the Iowa Hygenic Laboratory and North Dakota Department of Health Newborn Screening Program.

a. Last Year's Accomplishments
In both calendar years 2011 and 2010, 100 percent of newborns who screened positive for condition(s) mandated by the state newborn screening program received timely follow-up to definitive diagnosis and clinical management.

The ND Newborn Screening (NBS) Program contracts with the State Hygienic Lab at the University of Iowa to process NBS specimens. In addition, the NBS Program collaborates with the University of Iowa follow up staff and ND health-care providers regarding short-term follow-up on newborn screening cases.

Newborns with definitive diagnosis and need for clinical management were seen by the primary care provider and/or a medical consultant of choice within five to seven days of birth for long term planning and treatment management. Long-term follow up has primarily been addressed by: 1) providing medical food to individuals with phenylketonuria (PKU) and maple syrup urine disease (MSUD), 2) supporting quarterly Metabolic Disorders Clinics that result in coordinated disease management, and 3) providing diagnostic and treatment services for children birth to age 21 who meet medical and financial eligibility criteria.

The number of individuals receiving medical food and attending Metabolic Disorders Clinics has changed minimally over the last five years. All current newborn screening conditions are approved medical conditions for Children's Special Health Services (CSHS) coverage. With financial eligibility for treatment services legislatively mandated at 185 percent of the federal poverty level, changes in numbers eligible are not expected without consistent outreach or changes in income eligibility levels.

Program accomplishments within the 2011 federal fiscal year include:
• The ND NBS Program collaborated with the University of Iowa (IA) and Iowa Department of Health to develop an education plan. In addition, newborn screening staff provided education to facilities and information regarding specimen quality along with suggestions for improvement.
• The Heelstick newsletter was developed and distributed to newborn screening staff and healthcare providers in ND and IA. The newsletter can be viewed at the following website link: http://www.ndhealth.gov/newbornscreening/publications/heel_stick_news.pdf.
• Data related to confirmed cases was tracked on an informational table, which was shared with various stakeholders. Preliminary data and information has been assembled in preparation for the

completion of the ND Annual Report.
• Staff from CSHS, ND and IA NBS Programs met to collaborate on current issues affecting newborn screening and short-term and long-term follow up.
• The ND NBS Advisory Committee met to discuss ND NBS data related to confirmed positive cases and results from the health-care provider satisfaction survey. In addition, this committee advised the ND NBS Program on topics related to potential 2011 legislative bills, retention of dried blood spot specimens and recommendations related to the Secretary's Advisory Committee on Heritable Disorders. The ND NBS Advisory Committee provided consultation during the 2011 legislative session and some members of this group served as advocates for newborn screening.
• The ND NBS Program collaborated with the IA Department of Health to apply for funding to support a Quality Improvement Summit. Funding was awarded to ND and IA. This Summit is planned for Spring 2012.
• CSHS provided financial support through a service contract for four multidisciplinary metabolic disorders clinics during the year. The multidisciplinary clinic team is made up of a nurse, pediatric endocrinologist, social worker, pediatric nutritionist, educational specialist and pediatric psychologist.
• CSHS maintained an inventory of products within the division in order to provide 20-25 individuals who have PKU and MSUD with metabolic food and low protein modified food products. CSHS also provided state level care coordination services to eligible individuals with PKU and MSUD. In addition, CSHS developed a metabolic resource booklet to distribute to families of children with metabolic conditions.
• CSHS provided diagnostic and treatment services to eligible children with conditions identified through the NBS program.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The ND NBS Program collaborated with the University of Iowa (IA) and Iowa Department of Health to develop an education plan.				X
2. The Heelstick newsletter was developed and distributed to newborn screening staff and healthcare providers in ND and IA.		X		
3. Data related to confirmed cases was tracked on an informational table, which was shared with various stakeholders. Preliminary data and information has been assembled in preparation for the completion of the ND Annual Report.				X
4. Staff from CSHS, ND and IA NBS Programs met to collaborate on current issues affecting newborn screening and short-term and long-term follow up.				X
5. The ND NBS Advisory Committee met to discuss ND NBS data related to confirmed positive cases and results from the health-care provider satisfaction survey.				X
6. The ND NBS Program collaborated with the IA Department of Health to apply for funding to support a Quality Improvement Summit. Funding was awarded to ND and IA. This Summit is planned for Spring 2012.				X
7. CSHS provided financial support through a service contract for four multidisciplinary metabolic disorders clinics during the year.	X			
8. CSHS maintained an inventory of products within the division in order to provide 20-25 individuals who have PKU and MSUD with metabolic food and low protein modified food products.	X			
9. CSHS provided diagnostic and treatment services to eligible children with conditions identified through the NBS program.	X			
10.				

b. Current Activities

• Children's Special Health Services (CSHS) continues to support metabolic clinics, provide metabolic food and state level care coordination and provide diagnostic and treatment services to children with eligible newborn screening conditions.
• CSHS continues to discuss possible coverage of disease specific formula with ND Medicaid staff.
• Title V staff collaborate on issues related to newborn screening and follow-up.
• The Newborn Screening program is providing education to providers regarding current program issues.
• The Newborn Screening Program director is facilitating Tri-State Physician Case Review conference calls.

c. Plan for the Coming Year

• Periodic metabolic meetings will be held with the Newborn Screening Program director, Iowa follow-up staff and Children's Special Health Services (CSHS) staff to coordinate program goals and objectives.
• CSHS will support multidisciplinary clinics for children and women of childbearing age with metabolic disorders.
• CSHS will provide metabolic food to eligible individuals with PKU and MSUD.
• CSHS will continue to provide state level care coordination including implementation of a new notification process to help link families to available resources.
• CSHS will provide diagnostic and treatment services to eligible children that have conditions identified through the newborn screening program and potentially expand the conditions covered under inborn errors of metabolism.
• Title V staff will explore expansion of screening conditions (e.g., Critical Congenital Heart Disease, Severe Combined Immune Deficiency, etc.)
• Title V staff will continue to collaborate with the ND Genetic Advisory Committee and the Heartland Regional Collaborative.
• The Newborn Screening Program will continue to provide education to providers, families and the community.
• The ND Newborn Screening Director will provide regional co-coordination for ND, SD and IA Newborn Screening programs.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**10777**					
Reporting Year:	**2011**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	10777	100.0	1	1	1	100.0

Congenital Hypothyroidism (Classical)	10777	100.0	3	2	2	100.0
Galactosemia (Classical)	10777	100.0	2	1	1	100.0
Sickle Cell Disease	10777	100.0	1	1	1	100.0
Biotinidase Deficiency	10777	100.0	11	2	2	100.0
Cystic Fibrosis	10777	100.0	10	1	1	100.0
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	10777	100.0	3	1	1	100.0
Carnitine Palmitoyltransferase I deficiency	10777	100.0	0	0	0	
Carnitine palmitoyltransferase II deficiency	10777	100.0	0	0	0	

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	65	65	65	65	63.5
Annual Indicator	63.0	63.0	63.0	75.0	75.0
Numerator	10090	10090	10090	14443	14443
Denominator	16017	16017	16017	19262	19262
Data Source		See note field.	See note field.	See note field.	See note field.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	75.5	76	76.5	77	77.5

Notes - 2011
2011-For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
2010-For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2009
2009- Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.The data is weighted estimates.

a. Last Year's Accomplishments
According to the 2009/2010 National Survey of Children with Special Health Care Needs (NS-CSHCN), the percent of families that had CSHCN age 0 to 18 years in ND whose families were partners in shared decision-making for their child's optimal health was 75.0 percent. This was higher than the national percentage which was 70.3 percent.

Disparities in achievement of this outcome were noted in various subgroups in ND. The outcome was not achieved in 21.6 percent of White respondents compared to 39.1 percent in the Other Race/Ethnicity category. The outcome was not achieved in 24.2 percent of those who were currently insured compared to 55.3 percent who were not currently insured. Similar differences were noted in those whose current insurance was adequate compared to those whose insurance was not adequate.

Although national survey results are not comparable across survey years, the data from previous surveys is presented here for its historical value. According to the 2005/2006 NS-CSHCN, the percent of families that had CSHCN age 0 to 18 years in ND who partnered in decision-making at all levels and were satisfied with the services they received increased slightly from 61.5 percent in 2001 to 63.0 percent in 2005/2006. This is slightly higher than the national percentage, which was 57.5 in 2001 and 57.4 in 2005/2006.

In 2011, Family Voices of ND disseminated a report entitled In Search of an Answer, Listening and Responding: North Dakota Survey of Agencies Serving Children and Youth with Special Health Care Needs. The report identified the experiences families of children and youth with special health care needs faced as they searched for resources, information, financial support, emotional support and access to services. It also provided recommendations to transform the health care system to better meet the needs of children and youth with special health care needs in ND. The full report is available at the following website link: www.fvnd.org/yahoo_site_admin/assets/docs/FVND_Report_Final.33141636.pdf.

Family participation in CSHCN programs remains high, with a score of 17 out of a total of 18 points as documented on Form 13 -- Characteristics Documenting Family Participation in CSHCN Programs.

Ongoing Title V activities have focused on maintaining a Children's Special Health Services (CSHS) Family Advisory Council, funding family-led support organizations in the state, monitoring family satisfaction as a quality assurance activity and supporting activities that promote family-professional collaboration.

Program accomplishments within the 2011 federal fiscal year include:
• Children's Special Health Services (CSHS) staff members promoted family/professional collaboration by serving on the boards for Family Voices of ND and ND FamNet, a rural health network for family support. Involvement of families was encouraged by family participation in many CSHS meetings and the annual training event for local staff in addition to joint work on various collaborative projects.
• CSHS continued to support a Family Advisory Council that was scheduled to meet on a quarterly basis during the year. Family advice was documented in meeting minutes.
• CSHS sustained and enhanced support services for children and youth with special health care needs and their families within the state. Funding was provided to Family Voices of ND to support a wide array of services. CSHS also provided funding to support ND Hands and Voices, a new community outreach and education initiative for families with deaf and hearing impaired children. CSHS continued membership with ND FamNet, a nonprofit corporation/rural health network with the goal of enhancing family support.
• As part of the division's overall quality assurance plan, CSHS assessed family satisfaction and shared the results with stakeholders. Narrative addressing quality assurance activities, including client satisfaction, was required in all biennial grant applications submitted to CSHS. Satisfaction was also measured through various surveys that are conducted with families served by CSHS.
• Title V staff monitored activities that supported youth involvement and leadership such as the ND Department of Commerce's Youth Forward initiative. CSHS also maintained a list of youth/young adults as potential applicants for the CSHS Family Advisory Council although none were appointed.
An attachment is included in this section. IVC_NPM02_Last Year's Accomplishments

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Children's Special Health Services (CSHS) staff members promoted family/professional collaboration by serving on the boards for Family Voices of ND and ND FamNet, a rural health network for family support.				X
2. CSHS continued to support a Family Advisory Council that was scheduled to meet on a quarterly basis during the year. Family advice was documented in meeting minutes.				X
3. CSHS sustained and enhanced support services for children and youth with special health care needs and their families within the state.		X		
4. As part of the division's overall quality assurance plan, CSHS assessed family satisfaction and shared the results with stakeholders.				X
5. Title V staff monitored activities that supported youth involvement and leadership such as the ND Department of Commerce's Youth Forward initiative.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

• Children's Special Health Services (CSHS) continues to support a Family Advisory Council and conducts two to four meetings annually.
• CSHS promotes family/professional collaboration by participating on advisory boards of family organizations in the state and encouraging family involvement in related meetings, committees, training opportunities, work projects, etc.
• CSHS helps sustain and enhance family support services within the state by funding family-led organizations.
• CSHS staff are assessing family satisfaction levels with CSHS programs and report the results to stakeholders.
• Title V staff is monitoring and encouraging activities for youth, father involvement, and under-represented populations.
• Title V staff is utilizing feedback and resources from Family Voices of ND to enhance family satisfaction with services.

c. Plan for the Coming Year

• Children's Special Health Services (CSHS) will promote family/professional collaboration by participating on advisory boards of family organizations and encouraging family involvement in children with special health care needs (CSHCN) related meetings, committees, training opportunities, work projects, etc.
• CSHS will support a Family Advisory Council by conducting two to four meetings annually and documenting family advice and recommendations used in decision-making within the CSHS division.
• CSHS will sustain and enhance family support services within the state by funding family organizations that provide information/education, training (including leadership development), parent-to-parent programs, etc. for CSHCN and their families.
• CSHS will assess family partnerships and satisfaction (e.g., CSHS programs, Family Voices of ND, analysis of National Survey of Children with Special Health Care Needs, analysis of National Survey of Children's Health, etc.).
• CSHS will support planning and family attendance at the ND Summit on Causal Leadership.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	60	55	57	52	53
Annual Indicator	51.2	51.2	51.2	47.8	47.8
Numerator	8154	8154	8154	9156	9156
Denominator	15935	15935	15935	19170	19170
Data Source		See note field.	See note field.	See note field.	See note field.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

	2012	2013	2014	2015	2016
Annual Performance Objective	50	50.5	51	51.5	52

Notes - 2011
2011-Final 2010 data was used as provisional data for 2011. For 2011-2014, indicator data comes from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
2010-For 2011-2014, indicator data comes from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2009
2009- Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.The data is weighted estimates.

a. Last Year's Accomplishments
According to the 2009/2010 National Survey of Children with Special Health Care Needs (NS-CSHCN), the percentage of CSHCN in ND who received coordinated, ongoing, comprehensive care within a Medical Home was 47.8 percent, which is slightly higher than the national percentage of 43.0 percent. However, the percent of CSHCN served in a medical home decreased from 51.2 percent in 2005/2006 to 47.8 percent in 2009/2010.

Children's Special Health Services (CSHS) monitors the medical home status for children and youth who are eligible for the treatment program. While presently there is no process in place to assess the quality of care provided in the identified medical home, families are encouraged to list the provider they consider their child's primary care physician and efforts are made to assure care is coordinated.

CSHS has actively partnered with the ND Integrated Services (NDIS) Grant team to establish Medical Home pilot sites. Throughout the year, the team developed a care coordination training curriculum through a grant from the State Council on Developmental Disabilities.

CSHS provided financial support for care coordination services provided in medical home

practices through a contract with the ND Chapter of the American Academy of Pediatrics (NDAAP). Partners continue to support the Medical Home concept through staff time for collaborative meetings.

Program accomplishments within the 2011 federal fiscal year include:
• CSHS provided information on medical home to families through well-child/immunization packets. Family Voices of ND, an organization that CSHS contracts with to provide family health information services, continued to provide information on medical home to families through a variety of mediums. Links to North Dakota Integrated Services (NDIS) are located on the CSHS webpage.
• During the year, major collaboration around medical homes occurred through the work of ND's Medical Home team, which included representation from CSHS, Family Voices of ND, the NDAAP and Sanford Health. CSHS staff attended NDIS Advisory meetings, conference calls, and provided input into the development of a care coordination training curriculum. Title V staff also participated in the first meeting of the ND Coalition for Patient-Centered Medical Home. Other coordination occurred through the state Early Childhood Comprehensive Systems Initiative.
• CSHS monitored the medical home status of children served through CSHS as well as the percent of children who had comprehensive care coordination through local public health or county social service staff. Comprehensive care coordination was defined as information provision, a fully completed, written care coordination plan and assistance in accessing resources.
• CSHS staff continued to collaborate with the ND Center for Persons with Disabilities (NDCPD) on the NDIS project, which was funded April 2008 through May 2011. CSHS continued to fund medical home infrastructure through a liaison position with the NDAAP and provided care coordination reimbursement for the medical home pilot sites.
• To further knowledge of medical home in practice, state staff participated in conference calls, webinars, and learning collaboratives. State staff also attended the first meeting of the ND Coalition for Patient-Centered Medical Home.
• CSHS expanded coverage of primary care services by revising the policy for coverage of select primary care services.
• CSHS staff developed care coordination capacity of medical home pilot practices by offering technical assistance at quarterly learning collaboratives as well as scheduled NDIS Advisory meetings. State staff also reviewed and offered suggestions and resources to support development of several modules in the care coordination training curriculum developed by the NDCPD through a State Developmental Disabilities grant.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. CSHS provided information on medical home to families through well-child/immunization packets.		X		
2. During the year, major collaboration around medical homes occurred through the work of ND's Medical Home team, which included representation from CSHS, Family Voices of ND, the NDAAP and Sanford Health.				X
3. CSHS monitored the medical home status of children served through CSHS as well as the percent of children who had comprehensive care coordination through local public health or county social service staff.				X
4. CSHS staff continued to collaborate with the ND Center for Persons with Disabilities (NDCPD) on the NDIS project, which was funded April 2008 through May 2011.				X
5. To further knowledge of medical home in practice, state staff participated in conference calls, webinars, and learning collaboratives. State staff also attended the first meeting of the				X

ND Coalition for Patient-Centered Medical Home.				
6. CSHS expanded coverage of primary care services by revising the policy for coverage of select primary care services.				X
7. CSHS staff developed care coordination capacity of medical home pilot practices by offering technical assistance at quarterly learning collaboratives as well as scheduled NDIS Advisory meetings.				X
8.				
9.				
10.				

b. Current Activities

• CSHS monitors the medical home status of children receiving care coordination services who have a comprehensive, written service plan.
• CSHS is covering select primary care services for children served by CSHS.
• CSHS staff assisted in seeking out sources of funding to support implementation of medical homes and continues to provide grant funding to support medical home infrastructure.
• Title V staff are disseminating information on medical home such as best or promising practices, certification standards, research findings, current initiatives, and state and/or local opportunities for involvement.
• Title V staff collaborate with partners to further the medical home concept and practice in ND.

c. Plan for the Coming Year

• Children's Special Health Services (CSHS) will monitor the medical home status of children receiving care coordination services through CSHS and the percentage of children receiving CSHS care coordination services with a comprehensive, written service plan.
• Title V staff will disseminate information on medical and dental homes (e.g., best or promising practices, certification standards, research findings, current initiatives, and state and/or local opportunities for involvement, etc.).
• Title V staff will collaborate with partners to further the medical home concept and practice in ND (e.g., training, technical assistance and mentoring to enhance care coordination and screening; monitoring potential legislation; coordination with payers, etc.).
• Title V staff will explore sources of funding to support implementation of medical homes and provide grant funding to support medical home infrastructure development in ND.
• CSHS staff will provide state level care coordination to families on an as needed basis.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	65	68.4	69	69.5	70
Annual Indicator	68.2	68.2	68.2	60.1	60.1
Numerator	10981	10981	10981	11707	11707
Denominator	16093	16093	16093	19475	19475
Data Source		See note field.	See note field.	See note field.	See note field.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the					

last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	60.5	61	61.5	62	62.5

Notes - 2011
2011-Final 2010 data was used as provisional data for 2011. For 2011-2014, indicator data comes from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
2010-For 2011-2014, indicator data comes from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2009
2009- Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.The data is weighted estimates.

a. Last Year's Accomplishments
In 2011, the ND State Data Center reported 8.1 percent of children as uninsured using a three-year average estimate for children ages 0 to 17. Nationally, 9.9 percent of children were without health insurance coverage.

The 2007 National Survey of Children's Health reported 91.6 percent of ND children were currently insured (8.4% uninsured) compared to the national average of 90.9 percent (9.1% uninsured).

The percent of CSHCN without insurance has increased since the 2005/2006 National Survey of Children with Special Healthcare Needs (NS-CSHCN). At that time, 3.5 percent of children nationally were uninsured compared to 5.3 percent of ND children. The 2009/2010 NS-CSHCN reported 7.3 percent of ND children with special healthcare needs (CSHCN) were without insurance at some point during the past year compared to 9.3 percent in the nation.

According to an October 2009 Family Voices of ND report entitled "What Do North Dakota Families Say about Health Care for Children with Special Health Care Needs," 48.7 percent of families surveyed were satisfied or very satisfied with the covered costs of needed services for their CSHCN compared to 46 percent in 2006. However, 45.6 percent also indicated they had

financial stress due to their child's health care needs, a slight increase from 45 percent in 2006. In 2009, 42.9 percent indicated they understood or fully understood available health care financing options compared to 51 percent in 2006, an 8.1 percent decrease.

Program accomplishments within the 2011 federal fiscal year include:
• Children's Special Health Services (CSHS) monitored whether children served had a source of health care coverage. Over 90 percent of CSHCN served by CSHS had a source of health care coverage.
• CSHS had policies in place regarding coordination of payment between all available sources of health care coverage. Families applying for treatment services through CSHS were required to verify Medicaid and Healthy Steps eligibility as part of the application process. If ineligible, families were linked to other available resources. Information regarding Medicaid eligibility or support options such as the Children with Disabilities "Medicaid Buy-In" program and various waivers were also disseminated. CSHS staff disseminated a Health-Care Coverage Options brochure which can be viewed at: http://www.ndhealth.gov/cshs/docs/Health%20Care%20Coverage%20Options.pdf. Targeted outreach mailings were also sent to families with uninsured children served through CSHS clinics to link them to available sources of health care coverage.
• CSHS provided diagnostic services to over 100 children and treatment services to over 200 children. Service applications originating at the 53 county social service offices were reviewed by the CSHS Medical Director and state administrative staff to determine medical and financial eligibility. Staff also coordinated benefits when claims were received and reviewed care coordination plans submitted by local staff.
• CSHS staff attended meetings addressing the Medicaid Management Information System (MMIS) replacement project, Medicaid policy, and Medicaid pediatric health care issues, all of which impact services for CSHCN and their families.
• Title V staff monitored the impact of health care coverage legislation and policy changes for public programs affecting CSHCN and their families. The Caring for Children program's eligibility levels continued at 200 percent of poverty. Healthy Steps' income eligibility levels remained at 160 percent of poverty, but added orthodontic services to their list of covered services to children who meet the established criteria. CSHS remained at 185 percent of poverty. The ND Department of Human Services received CHIP outreach dollars that were contracted to the Dakota Medical Foundation for outreach activities.
• In an effort to enhance the state's capacity to provide health benefits counseling, Title V staff continued to promote Bridge to Benefits, a Children's Defense Fund initiative that connects individuals to public programs. Staff also monitored health care reform legislation and its implications for the CSHCN population. CSHS partnered with FamNet to submit a grant that would address health benefits counseling.
• Title V staff continue to monitor the impact of healthcare reform on CSHCN.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Children's Special Health Services (CSHS) monitored whether children served had a source of health care coverage. Over 90 percent of CSHCN served by CSHS had a source of health care coverage.				X
2. CSHS had policies in place regarding coordination of payment between all available sources of health care coverage.				X
3. CSHS provided diagnostic services to over 100 children and treatment services to over 200 children.	X			
4. CSHS staff attended meetings addressing the Medicaid Management Information System (MMIS) replacement project, Medicaid policy, and Medicaid pediatric health care issues, all of which impact services for CSHCN and their families.				X

5. Title V staff monitored the impact of health care coverage legislation and policy changes for public programs affecting CSHCN and their families.				X
6. In an effort to enhance the state's capacity to provide health benefits counseling, Title V staff continued to promote Bridge to Benefits, a Children's Defense Fund initiative that connects individuals to public programs.		X		
7. Title V staff continue to monitor the impact of healthcare reform on CSHCN.				X
8.				
9.				
10.				

b. Current Activities

• Children's Special Health Services (CSHS) is monitoring the number of children with special health care needs (CSHCN) served by CSHS with a source of health care coverage.
• CSHS is providing diagnostic and treatment services to eligible uninsured and underinsured CSHCN.
• Title V staff are conducting activities to refer, link, and counsel families that have CSHCN to increase access to available sources of health care coverage.
• Title V and Department of Human Services staff are coordinating regarding claims payment, Medicaid policies/programs, waivers for children with extraordinary medical needs, and services to CSHCN and their families.
• Title V is partnering with others to enhance the state's capacity to provide health benefits counseling and health system advocacy.
• Title V staff is keeping actively informed and notifying others regarding anticipated impact of health care reform.

c. Plan for the Coming Year

• Children's Special Health Services (CSHS) will monitor the number of Children with Special Health Care Needs (CSHCN) with a source of health care coverage (e.g., CSHS, National Survey of Children with Special Health Care Needs, the National Survey of Children's Health, etc.).
• CSHS will provide payment for diagnostic and treatment services to eligible uninsured and underinsured CSHCN.
• CSHS staff will obtain training needed to effectively utilize the new Medicaid claims and eligibility systems if they are put into production.
• Title V staff will conduct activities to inform, refer, link, and counsel families that have CSHCN to increase access to available sources of health care coverage and other assistance programs (e.g., clinic registration and billing departments).
• Title V staff will coordinate with Department of Human Services staff regarding claims payment, Medicaid policies/programs, new waivers, and services for CSHCN and their families.
• Title V staff will monitor state and federal health care coverage legislation that impacts children as well as state policy changes that affect Medicaid, the Children's Health Insurance Program, the Caring for Children program, and CSHS eligibility or covered services.
• Title V staff will partner with others to enhance the state's capacity to provide health benefits counseling and health system advocacy (e.g., Bridge to Benefits, Who Pays? Taking the Maze out of Funding publication and training, FamNet grant for health benefits counseling infrastructure development, etc.).

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	85	93	93	93.5	93
Annual Indicator	92.3	92.3	92.3	67.9	67.9
Numerator	15201	15201	15201	13149	13149
Denominator	16464	16464	16464	19379	19379
Data Source		See note field.	See note field.	See note field.	See note field.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	68	68.5	69	69.5	70

Notes - 2011
2011-Final 2010 data was used as provisional data for 2011. For 2011-2014, indicator data comes from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
2010-For 2011-2014, indicator data comes from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2009
2009- Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.The data is weighted estimates.

a. Last Year's Accomplishments

According to the 2009/2010 National Survey of Children with Special Health Care Needs (NS-CSHCN) 67.9 percent of ND respondents reported no difficulty or frustration accessing services for their child in the past 12 months, compared to 65.1 percent nationally. The questions for this outcome measure were changed in the 2009/2010 NS-CSHCN so the results will become the new baseline for ND. In previous years, this outcome was monitored in the 2005/2006 NS-CSHCN which asked parents if the community-based service systems were usually or always organized so they could easily use them. In that survey, 92.3 percent of families reported that the services were organized so they could easily use them, compared to 89.1 percent nationally. This was an increase from the 2001 survey when 83 percent of ND respondents thought that community-based service systems were usually or always organized so they could easily use them.

According to an October 2009 Family Voices of ND report entitled "What Do North Dakota Families Say about Health Care for Children with Special Health Care Needs", 51 percent of families responded they were very satisfied or satisfied with their comfort level in accessing comprehensive, community based services for their child and family and that they knew who to call for service information. This result was down from 53 percent in 2006.

Program accomplishments within the 2011 federal fiscal year include:

• To enhance capacity of local staff implementing Children's Special Health Services (CSHS) programs, state staff conducted two site visits, a new county worker training, and provided technical assistance to county social service and public health nursing staff as it was needed. Local staff were also notified of additional training opportunities that were available within the state. CSHS staff participated in training opportunities covering a variety of topics.

• To improve services for Children with Special Health Care Needs (CSHCN), CSHS staff participated on 38 interagency workgroups and committees during FFY 2011.

• CSHS supported ten different types of multidisciplinary clinics, two of which were managed by state CSHCN staff and eight that were funded through service contracts. Over 300 children received services through contracted clinics and approximately 800 children received services through clinics that were directly managed by CSHS staff.

• CSHS continues to disseminate condition specific resource booklets for children with congenital heart conditions, autism, and cleft lip and palate. Two additional resource booklets were developed and disseminated for children with diabetes and metabolic conditions.

• CSHS held a statewide clinic coordinator meeting to enhance the delivery of multidisciplinary and specialty clinic services in September 2011. Clinic coordinators along with other members of their respective organizations and the Director of Family Voices of ND participated in the conference call meeting. A teleconference with the clinic coordinators of the Cardiac Care for Children program was also held.

• CSHS promoted access to pediatric specialists and promoted available outreach services. Staff from the Shriners Clinic in Minneapolis, MN conducted outreach and screening clinics in ND. A pediatric physiatrist from Minnesota offered outreach services in Bismarck and pediatric cardiologists from Minnesota continued to offer services in four ND cities. The 2011 Multidisciplinary Clinic Directory contained a list of multidisciplinary clinics available to CSHCN and their families. This directory was distributed to approximately 2,000 community agencies and providers and included a list of ND pediatricians and pediatric specialists.

• CSHS partnered with various organizations to help families locate services. CSHS provided links to family support organizations through the division's website and distributed information regarding family support organizations through direct mailings and display opportunities. CSHS and various family support services were included in informational resources, newsletters, help lines, websites and social media options.

• State level CSHS staff provided care coordination support to link families to specialty health services in and outside the state. Staff also provided information related to the child's special health care need and various health care coverage programs. Some families required extensive support to coordinate care provided by multiple providers and payers.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Children's Special Health Services (CSHS) programs, state staff conducted two site visits, a new county worker training, and provided technical assistance to county social service and public health nursing staff.				X
2. To improve services for Children with Special Health Care Needs (CSHCN), CSHS staff participated on 38 interagency workgroups and committees during FFY 2011.				X
3. CSHS supported ten different types of multidisciplinary clinics, two of which were managed by state CSHCN staff and eight that were funded through service contracts.	X			
4. CSHS continues to disseminate condition specific resource booklets for children with congenital heart conditions, autism, and cleft lip and palate.		X		
5. CSHS held a statewide clinic coordinator meeting to enhance the delivery of multidisciplinary and specialty clinic services in September 2011.				X
6. CSHS promoted access to pediatric specialists and promoted available outreach services. Staff from the Shriners Clinic in Minneapolis, MN conducted outreach and screening clinics in ND.		X		
7. CSHS partnered with various organizations to help families locate services.				X
8. State level CSHS staff provided care coordination support to link families to specialty health services in and outside the state.				X
9.				
10.				

b. Current Activities

• Children's Special Health Services (CSHS) is enhancing capacity of local staff to implement CSHS programs by providing technical assistance and training opportunities.
• CSHS is directly managing and funding a variety of multidisciplinary clinics services for children with special health care needs (CSHCN) and their families.
• CSHS staff participates on interagency workgroups and committees whose focus is expected to improve services and systems for CSHCN.
• CSHS supports access to specialty care by monitoring the number, location and board certification status of physicians, disseminating a list of available ND pediatric specialists and promoting outreach services.
• CSHS provides state level care coordination to link CSHCN and their families to specialty health services in the state.
• Title V staff partner with others to assist and support families of CSHCN in accessing information and locating services.

c. Plan for the Coming Year

• Evaluate the ongoing capacity of Children's Special Health Services (CSHS) county workers to provide eligibility determination and care coordination services for children with special health care needs (CSHCN) and their families.
• Monitor legislation that would support enhanced community-based service delivery (e.g., autism services).
• CSHS will provide technical assistance and/or training to the public health care coordinator, local county social service staff, clinic coordinators and cardiac program liaisons.

• CSHS will explore options to directly manage or fund a variety of multidisciplinary clinic services for CSHCN and their families.
• CSHS will support access to specialty care by monitoring the number, location and board certification status of pediatricians and pediatric sub-specialists within the state; disseminating a multidisciplinary clinic directory that includes a listing of available ND pediatric specialists; and promoting use of outreach services such as Shriners' clinics, the dental care mobile, and the cardiac program.
• CSHS will provide state level care coordination to link CSHCN and their families to specialty health services in the state.
• Title V staff will participate in interagency workgroups and committees whose focus is expected to improve services for CSHCN.
• Title V staff will partner with others to assist and support families of CSHCN in accessing information and locating services (e.g., Family Voices topical calls and Parent Navigator teams, Bridge to Benefits, 877-KIDS NOW, NDSU Extension, A Connection for Families and agency resource booklets, etc.).
• CSHS will provide information and referral services to families and collaborate with other stakeholders involved with children's Supplemental Security Income (SSI).

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	10	52	52	54	52
Annual Indicator	51.2	51.2	51.2	46.5	46.5
Numerator	3651	3651	3651	4021	4021
Denominator	7125	7125	7125	8642	8642
Data Source		See note field.	See note field.	See note field.	See note field.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	47	47.5	48	48.5	49

Notes - 2011
2011-Final 2010 data was used as provisional data for 2011. For 2011-2014, indicator data comes from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
2010-For 2011-2014, indicator data comes from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2009
2009- Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.The data is weighted estimates.

a. Last Year's Accomplishments
According to the 2009/2010 National Survey of Children with Special Healthcare Needs (NS-CSHCN), the percent of youth with special health care needs who received the services necessary to make transitions to adult health care, work, and independence was 46.5, which is higher than the national percentage of 40.0. These survey results showed a decrease when compared to the 2005/2006 NS-CSHCN which indicated 51.2 percent of youth received the necessary services compared to 41.2 percent nationally.

According to the ND Department of Public Instruction's Post-school Outcomes Survey evaluating the 2009-2010 school year, 76.4 percent of exiting students receiving special education services had health insurance. This was an increase from 73.9 percent in the previous school year.

In the area of transition, Children's Special Health Services (CSHS) continues to build partnerships and encourage emphasis on health transition issues such as continuous health care coverage and health advocacy for youth and young adults. Examples of such collaboration included working toward consistent representation on the state's Community of Practice on Transition team as well as coordinating a subcommittee focused on healthy transitions.

Program accomplishments within the 2011 federal fiscal year include:
• To foster collaboration promoting healthy transitions, Title V staff participated in: 1) ND Community of Practice on Transition led by the Department of Public Instruction, 2) planning and attended learning collaboratives through the ND Integrated Services (NDIS) Grant, and 3) presentations at the "Resource Roundup" during the Annual ND Transition Conference, sponsored by ND Federation of Families for Children's Mental Health in July 2011.
• CSHS monitored the level of transition planning for CSHCN age 14 to 21 receiving CSHS care coordination. Staff also provided suggestions of potential service availabilities.
• CSHS staff continued to provide outreach mailings to families whose children were referred from Disability Determination Services to assure families had access to information and referral services. State staff led an annual Supplemental Security Income (SSI) meeting with

representatives from Medicaid, the Social Security Administration, Disability Determination Services, Family Voices of ND and the State CSHCN program.
• CSHS continued to distribute age-appropriate health care transition resources to all transition aged youth and young adults age 14 to 21 served by CSHS.
• CSHS promoted transition through a variety of program activities. Transition was addressed in care coordination service plans for youth age 14 to 21served through the diagnostic and treatment programs. Transition-aged youth that participated in the CSHS multidisciplinary clinics were provided with health care transition resources.
• Transition-related information was provided to ND Integrated Services (NDIS) learning collaborative participants and attendees of the Annual Transition Community of Practice Conference. Strategies for outreach to transition-aged youth were discussed with the Grand Forks Public Health Care Coordination staff.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. To foster collaboration promoting healthy transitions, Title V staff participated various meetings and provided presentations.				X
2. CSHS monitored the level of transition planning for CSHCN age 14 to 21 receiving CSHS care coordination. Staff also provided suggestions of potential service availabilities.				X
3. CSHS staff continued to provide outreach mailings to families whose children were referred from Disability Determination Services to assure families had access to information and referral services.		X		
4. CSHS continued to distribute age-appropriate health care transition resources to all transition aged youth and young adults age 14 to 21 served by CSHS.		X		
5. CSHS promoted transition through a variety of program activities. Transition was addressed in care coordination service plans for youth age 14 to 21served through the diagnostic and treatment programs.				X
6. Information was provided to ND Integrated Services (NDIS) learning collaborative participants and attendees of the Annual Transition Community of Practice Conference.				X
7.				
8.				
9.				
10.				

b. Current Activities
• Children's Special Health Services (CSHS) is collaborating with state agencies, local providers and family organizations to promote health care transitions for children and youth with special health care needs.
• CSHS continues to monitor the level of transition service planning for children ages 14 to 21 served by CSHS with a written service plan.
• CSHS provides information and referral services to families and collaborates with other stakeholders involved with children's Supplemental Security Income (SSI).
• CSHS is disseminating health care transition resources.
• CSHS is promoting transition through multidisciplinary clinics, care coordination and diagnostic and treatment programs.
• Title V is advocating for inclusion of disability and chronic illness questions in the Youth Risk Behavior Survey so results and strategies can be shared with school nurses and other partners.

c. Plan for the Coming Year

• Children's Special Health Services (CSHS) will collaborate with state agencies, local providers and family organizations to promote health care transitions for children and youth with special health care needs (e.g., the Department of Public Instruction's Community of Practice and subcommittees).
• CSHS will explore opportunities to provide transition-based trainings for youth with special health care needs and their families.
• CSHS will review and provide feedback regarding transition activities for children ages 14 to 21 that are included in the CSHS care coordination plan.
• CSHS will disseminate health care transition resources through a variety of strategies (e.g., websites, information packets, transition fairs, etc.).
• CSHS will promote transition through multidisciplinary clinics, care coordination and diagnostic and treatment programs.
• CSHS will enhance transition-related information such as family planning and graduated license to encourage more collaboration around youth transition.
• Title V staff will advocate that the Youth Risk Behavior Survey continues to collect disability data and provide results and strategies to school nurses and other transition partners.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	85.5	85.5	86	86	58
Annual Indicator	84.2	81.7	57.6	78.4	78.4
Numerator	19876	19286	7020	9985	9985
Denominator	23606	23606	12187	12736	12736
Data Source		See note field.	See note field.	See note field.	See note field.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	79	79.5	80	80.5	81

Notes - 2011

2011-Final 2010 data was used as provisional data for 2011. The sources for this data are the CDC National Immunization Survey and the Bureau of Census. The numerator is derived from back calculation. In 2009, the percent of 19 to 35 month olds who received immunizations is lower due to shortage of Haemophilus influenzae type b (Hib) vaccine. The denominator is from the U.S. Census Bureau, Population Division Census 2010. Note: Prior to 2009, the source for demominator data was 2000 census. Note: Prior to CY 2010, the numerator is the number of resident children who have received the complete immunization schedule for DTP/DTAP, OPV, measles, mumps, rubella (MMR), H. influenza, and hepatitis B before their second birthday.

Complete immunization status is generally considered to be: 4 DtaP, 3 Polio, 1 MMR, 3 Hib, 3 Hepatitis B (4:3:1:3:3) . The numerator for 2010 for North Dakota includes 4 DtaP, 3 Polio, 1 MMR, 3 Hib, 3 Hepatitis B and 1 Varicella (4:3:1:3:3: 1). Data in 2010 includes immunization for Varicella in the current immunization series (4:3:1:3:3: 1). Data from 2009 and 2010 should not be compared with prior years because of changes in measurement for the vaccine series.

Notes - 2010
2010-The sources for this data are the CDC National Immunization Survey and the Bureau of Census. The numerator is derived from back calculation. In 2009 the percent of 19 to 35 month olds who received immunizations is lower due to shortage of Haemophilus influenzae type b (Hib) vaccine. The denominator is from the U.S. Census Bureau, Population Division Census 2010. Note: Prior to 2009, the source for demominator data was 2000 census. Note: Prior to CY 2010, the numerator is the number of resident children who have received the complete immunization schedule for DTP/DTAP, OPV, measles, mumps, rubella (MMR), H. influenza, and hepatitis B before their second birthday. Complete immunization status is generally considered to be: 4 DtaP, 3 Polio, 1 MMR, 3 Hib, 3 Hepatitis B (4:3:1:3:3) . The numerator for 2010 for North Dakota includes 4 DtaP, 3 Polio, 1 MMR, 3 Hib, 3 Hepatitis B and 1 Varicella (4:3:1:3:3: 1). Data in 2010 includes immunization for Varicella in the current immunization series (4:3:1:3:3: 1). Data from 2009 and 2010 should not be compared with prior years because of changes in measurement for the vaccine series.

Notes - 2009
2009-The sources for this data are the CDC National Immunization Survey and the Bureau of Census for population estimates. The numerator is derived from back calculation. In 2009 the percent of 19 to 35 month olds who received immunizations is lower due to shortage of Haemophilus influenzae type b (Hib) vaccine. The denominator is from the U.S. Census Bureau, Population Division, Vintage 2008 Population Estimates, Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: April 1, 2000 to July 1, 2009. Note-Prior to 2009 the source for demominator data was 2000 census.

a. Last Year's Accomplishments
This performance measure reflects the series (4:3:1:3:3) of childhood vaccine consisting of four doses of diphtheria, tetanus and pertussis vaccine (DTP); three doses of Polio; one dose of Measles, Mumps, and Rubella (MMR); three doses of Haemophilus Influenzae type B vaccine (Hib); and three doses of Hepatitis B vaccine. The Centers for Disease Control and Prevention (CDC) National Immunization Survey (NIS) no longer tracks the 4:3:1:3:3 series.

ND follows the recommended series (4:3:1:3:3:1) of childhood vaccine which consists of four doses of DTP vaccine; three doses of Polio; one dose of MMR; three doses of Hib; three doses of Hepatitis B vaccine; and one or more doses of the Varicella vaccine. ND's percentage for the 4:3:1:3:3:1 series, according to the 2009 NIS was 77.8. The U.S. percentage for the same series and year is 75.7. There are some caveats related to this data. Due to the Hib shortage, this percentage does not include the booster dose of Hib vaccine, which was deferred. Also, there are two types of Hib vaccines, a three-dose and a four-dose vaccine. Previously, CDC based percentages on three doses. In order to increase accuracy, these percentages are now based on the type of Hib vaccine used. Thus, comparisons to the data from the previous year are difficult.

Comparison data for the 4:3:1:0:3:1:4 series was available (four doses of DTP vaccine; three doses of Polio; 1 dose of MMR; zero for Hib, as this was excluded due to the shortage of the vaccine; 3 doses of Hepatitis B vaccine; 1 dose of Varicella vaccine; and 4 doses of Pneumococcal conjugate vaccine [MCV]). In 2009, the ND 4:3:1:0:3:1:4 series percentage was 77.0; in 2008, it was and 69.7. In 2009, the U.S. percentage for the same series was 70.5 percent; virtually unchanged from 70.6 percent in 2008.

The Immunization program continued to assess school immunization data in 2010. The school immunization data showed that children entering kindergarten for the 2010-2011 school year had

the following percentages: Polio -- 92.36; DTP/DTaP/DT -- 92.28; MMR -- 91.96; Hepatitis B -- 94.73; and Varicella (includes immunity from vaccine or disease) -- 91.66. The survey also showed that 12 kindergartners had vaccination exemptions due to medical reasons, 17 due to religious reasons, 68 due to philosophical reasons and 32 due to moral reasons.

Middle School immunization percentages for 2010 were as follows: Polio -- 99.04; DTP/DTaP/DT -- 95.07; MMR -- 99.45; Hepatitis B -- 99.14; Varicella (includes immunity from vaccine or disease) -- 71.59; Td/Tdap -- 68.53; and MCV 4 -- 66.42. The survey also showed that 11 seventh graders had vaccination exemptions due to medical reasons, 16 due to religious reasons, 45 due to philosophical reasons and 12 due to moral reasons.

Program accomplishments within the 2011 federal fiscal year include:
• The Immunization Program continued to collaborate with Maternal and Child Health (MCH) through a Memorandum of Agreement.
• Immunization trainings and updates were provided to health-care partners such as school nurses, childcare health consultants, Head Start, Women, Infants and Children (WIC) and local public health.
• Immunization records of children were assessed through a variety of ways. WIC staff reviewed immunization records and/or checked immunization status and referred as needed. The Immunization Program surveyed school immunization rates. Local public health units assisted schools in determining up-to-date status of students.
• Immunization information was distributed through a variety of communication methods. WIC staff entered immunization information into the WIC computer system during certification visits. Children's Special Health Services (CSHS) distributed well-child information packets that included an immunization periodicity schedule. The Immunization Program website provided online information including distribution of quarterly immunization newsletters.
• CSHS provided payment for select immunizations for children eligible for treatment services.
• Twenty local health departments utilized MCH funding for immunization administration.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Immunization Program continued to collaborate with Maternal and Child Health (MCH) through a Memorandum of Agreement.				X
2. Immunization trainings and updates were provided to health-care partners such as school nurses, childcare health consultants, Head Start, Women, Infants and Children (WIC) and local public health.				X
3. Immunization records of children were assessed through a variety of ways.			X	
4. Immunization information was distributed through a variety of communication methods.		X		
5. CSHS provided payment for select immunizations for children eligible for treatment services.	X			
6. Twenty local health departments utilized MCH funding for immunization administration.			X	
7.				
8.				
9.				
10.				

b. Current Activities

• Local Women, Infants and Children (WIC) staff record the immunization status of infants and children at each WIC certification and refer when needed.
• Immunization resources such as newsletters and immunization schedules are available in hard copy and online through the ND Department of Health (e.g., Parenting The First Year Magazine).

c. Plan for the Coming Year
• Continue collaboration between Maternal and Child Health (MCH) and the Immunization Program through the Title V Memorandum of Agreement.
• Provide immunization trainings and updates to school nurses; child care health consultants; Head Start health consultants; Women, Infants and Children (WIC), and local public health staff in collaboration with the Immunization Program.
• Direct service Title V programs/grantees and WIC will review immunization records of all children and refer as needed.
• Provide immunization information through various communication methods such as newsletters, well child packets and access to online information.
• Review the use of Title V funds for immunization administration in local public health units.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	10.4	11	10	11	9.1
Annual Indicator	11.3	11.3	12.1	12.6	12.6
Numerator	514	513	511	500	500
Denominator	45339	45339	42406	39617	39617
Data Source		See note field.	See note field.	See note field.	See note field.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	12.4	12.2	12	11.8	11

Notes - 2011
2011-Final 2010 data was used as provisional data for 2011. The sources for this data are the North Dakota Department of Health -- Division of Vital Statistics and the U.S. Census Bureau, Population Division. The numerator is a three-year total. The source of the denominator is from 2010 Census for 15 through 17-year-old females in North Dakota. Note: Prior to 2009, the source for demominator data was 2000 census. Note: The denominator is the number of female teenagers 15 through 17 in North Dakota.

Notes - 2010
2010-The sources for this data are the North Dakota Department of Health -- Division of Vital Statistics and the U.S. Census Bureau, Population Division .The numerator is a three-year total.

The source of the denominator is from 2010 Census for 15 through 17-year-old females in North Dakota. Note: Prior to 2009, the source for demominator data was 2000 census. Note: The denominator is the number of female teenagers 15 through 17 in North Dakota.

Notes - 2009
2009- The sources for this data are the North Dakota Department of Health -- Division of Vital Statistics and the Bureau of Census for population estimates. The numerator is a three-year total of teenagers 15 through 17 who gave birth during the calender years. The denominator is a Census estimate of 15 through 17-year-old females. The denominator is from the U.S. Census Bureau, Population Division, Vintage 2008 Population Estimates, Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: April 1, 2000 to July 1, 2009. Note-Prior to 2009 the source for demominator data was 2000 census.

a. Last Year's Accomplishments
The three-year rate of birth for teenagers aged 15 through 17 years was 12.6 per 1,000 births in 2010. This is a slight increase from the three-year rate of 12.1 per 1,000 births in 2009.

While there is not a specific ND teen pregnancy prevention task force, there is a ND Stakeholders Collaboration group made up of staff from the Department of Public Instruction (HIV/AIDS), the Department of Health (abstinence, family planning, HIV/AIDS, STD, MCH, coordinated school health, Office for the Elimination of Health Disparities) and the Indian Affairs Commission that received technical assistance and a small grant from the National Stakeholders Collaborative (NSC). The NSC came to ND in April 2010 for a two day planning session that focused on enhancing communication and collaboration to strengthen HIV, STD and unintended pregnancy prevention programs for youth. As a result of this Stakeholders collaboration, an American Indian Adolescent Sexual Health conference was held on March 11, 2011. The conference included presentations and small group discussions focusing on American Indian reproductive health issues. A summary of the conference was shared with a variety of partners. In addition, this information will be used by the Family Planning Program moving forward in 2012 with efforts to strengthen tribal programs and relationships. A Tell-It-To-Me Straight dinner was held February 28, 2011. Forty parents attended the dinner to learn about the realities and pressures teens face relating to sexuality and to be better equipped to open lines of communication with their teens.

Program accomplishments within the 2011 federal fiscal year include:
• Between October 1, 2010 and June 30, 2011, abstinence grantees continued with program activities. Make a Sound Choice provided services to participants throughout the state including approved curricula educator training (Train the Teacher) and abstinence education programs. The curriculum was a character-based risk avoidance curriculum focused on sexual abstinence. This material was purchased from A&M Partnership and has been reviewed for accuracy by the U.S. Department of Health and Human Services. Northern Lights Youth Services implemented "BreakDown" -- a youth-based abstinence education program first developed in Tucson, Arizona which is a blend of drama, dance, video, testimonials and motivational speakers with the goal to captivate the audience and provide accurate information (abstinence until marriage lifestyle is both popular and cool as well as the only safe choice). Funding for the Abstinence Education program was removed from the Department of Health's budget during the 2011 legislative session; hence funding for the Abstinence program ended on June 30, 2011.
• In 2011, the ND Family Planning program provided services to 1,068 female clients and 41 male clients less than 18 years of age. A total of 959 female clients' under the age of 18 years choose a primary birth control method. Options counseling was provided for the 13 positive pregnancy tests for the clients in this age range. Medical and counseling services provided to adolescents are confidential. All adolescents are encouraged to include their parent/guardian in their reproductive life plan. Family Planning clinicians document all family involvement and counseling provided.
• Each Family Planning program has an active Information and Education (I&E) Committee that reviews and approves all educational materials utilized by the agency, which includes information provided to adolescents on reproductive health issues. The I&E Committee's membership

consists of adolescents, health care providers and members representative of the general community.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Between October 1, 2010 and June 30, 2011, abstinence grantees continued with program activities.				X
2. In 2011, the ND Family Planning program provided services to 1,068 female clients and 41 male clients less than 18 years of age. A total of 959 female clients' under the age of 18 years choose a primary birth control method.	X			
3. Each Family Planning program has an active Information and Education (I&E) Committee that reviews and approves all educational materials utilized by the agency, which includes information provided to adolescents on reproductive health issues.		X		
4.				
5.				
6.				
7.				
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b. Current Activities

• The Family Planning Program is providing direct, confidential medical, counseling, laboratory and contraceptive services to adolescents, including services on two Indian Reservations.
• The Family Planning program has analyzed data relating to American Indian teen pregnancy rates and has initiated conversations with the Turtle Mountain Band of Chippewa to discuss teen pregnancy prevention strategies.
• Family Planning delegate agency staff provides educational resources to parents about how to talk to their adolescents about sexuality issues.
• Family Planning delegate agency staff provides counseling and education to all adolescent clients about the importance of family involvement in reproductive health decisions and avoidance of sexual coercion.

c. Plan for the Coming Year

• The Family Planning Program will continue to provide direct, confidential medical, counseling, laboratory and contraceptive services to adolescents, including services on two Indian Reservations.
• The Family Planning delegate agency staff will provide educational resources to parents about how to talk to their adolescents about sexuality issues.
• The Family Planning delegate agency staff will provide counseling and education to all adolescent clients about the importance of family involvement in reproductive health decisions and avoidance of sexual coercion.
• The Family Planning Program will partner with Turtle Mountain Band of Chippewa to develop teen pregnancy prevention activities/programs.
• The State School Nurse Consultant will provide resources and technical assistance to school nurses on health education topics.
• Title V staff/programs will provide information on healthy relationship evidence-based programs to share with their partners (e.g., school nurses, Family Planning clinics, domestic violence).

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	54	54.5	55	55.5	61
Annual Indicator	53.0	53.0	60.4	60.4	60.4
Numerator	3738	3738	4024	4024	4024
Denominator	7052	7052	6662	6662	6662
Data Source		See note field.	See note field.	See note field.	See note field.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	61.5	62	65	70	72

Notes - 2011
2011-Final 2010 data was used as provisional data for 2011. The source for this data is the North Dakota Department of Health Oral Health Basic Screening Survey for the 2009-2010 school year. The sample screened for this performance measure is from a specific representative sample of third grade children in North Dakota. The denominator is the number of third grade children enrolled in North Dakota for the school year 2009-2010.

Notes - 2010
2010-The source for this data is the North Dakota Department of Health Oral Health Basic Screening Survey for the 2009-2010 school year. The sample screened for this performance measure is from a specific representative sample of third grade children in North Dakota. The denominator is the number of third grade children enrolled in North Dakota for the school year 2009-2010.

Notes - 2009
2009-The source for this data is the North Dakota Department of Health Oral Health Basic Screening Survey for the 2009-2010 school year. The sample screened for this performance measure is from a specific representative sample of third grade children in North Dakota. The denominator is the number of third grade children enrolled in North Dakota for the school year 2009-2010.

a. Last Year's Accomplishments
During the 2009-2010 school year, the ND Department of Health conducted a statewide Basic Screening Survey (BSS) of third grade children enrolled in public, state or Bureau of Indian Affairs elementary schools in the state. The survey found that 60 percent of third grade children have received protective sealants on at least one permanent molar tooth. This exceeds the Healthy People 2010 goal of 50 percent. The percentage of sealants is on the rise, although no increase has occurred among children in low-income populations. Results from the 2009-2010 BSS can be viewed at: http://www.ndhealth.gov/oralhealth/publications/2009-2010%20BSS%20Data%20Tables.pdf

In August 2010, the Oral Health program received an Oral Health Workforce grant that focuses on direct services. Implementation of a statewide sealant program, Seal!ND, was part of the approved workplan. Year one of the grant was used to plan and purchase supplies and equipment. In addition, four public health hygienists were hired and trained to provide direct services. The school-based sealant and fluoride varnish program started in September 2011. Both programs are provided at no cost to the students or school. Schools were selected for participation based on 50 percent or more, free and reduced lunch rates. The grant also supports the Ronald McDonald House Charities Dental Care Mobile and a dental safety net clinic that provides preventive and restorative services to residents in long-term care facilities.

Program accomplishments within the 2011 federal fiscal year include:
• On September 30, 2011, the Oral Health Program director co-chaired the ND Pediatric Dental Day, a project of the Head Start Dental Home Initiative, which was held at the Spirit Lake Reservation. More than 50 dental professional and 40 volunteers came together to help the children of the Spirit Lake Nation. More than 1,100 dental procedures (worth nearly $108,000) were performed on 232 children and other recipients. Recipients received dental screenings, cleanings, sealants, fluoride varnish, restorative care, education and prevention materials. A video overview of the ND Spirit Lake Pediatric Dental Day can be viewed at: http://www.ndhealth.gov/oralhealth/DentalDay/SpiritLake.htm.
• The State Oral Health Program director continued to serve on the Ronald McDonald House Charities Dental Care Mobile Executive Committee. The Dental Care Mobile was ordered in June 2011 and is expected to arrive in January 2012. Direct services are expected to begin in February 2012 in Bismarck and expand to area communities within the first six months. The Dental Care Mobile will be serving children up to age 21 and will provide prevention and restorative services, which includes sealants.
• Children's Special Health Services paid for protective sealants for children with eligible dental conditions.
• The State Oral Health Program director and other Title V staff participated on the Oral Health Coalition. The Oral Health Coalition hosted a priority policy meeting in 2010 which included many oral health advocates such as public health, community health centers, dental hygienists, the state dental and dental hygiene associations and others. Attendees helped to determine the top five priority polices for ND.
• The Oral Health Program published Oral Health Program Accomplishments for 2010-2011. The document can be viewed at: http://www.ndhealth.gov/oralhealth/Publications/Fact_Sheet_Accomplish2010-2011.pdf.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. On September 30, 2011, the Oral Health Program director co-chaired the ND Pediatric Dental Day, a project of the Head Start Dental Home Initiative, which was held at the Spirit Lake Reservation.	X			
2. The State Oral Health Program director continued to serve on the Ronald McDonald House Charities Dental Care Mobile Executive Committee.				X
3. Children's Special Health Services paid for protective sealants for children with eligible dental conditions.	X			
4. The State Oral Health Program director and other Title V staff participated on the Oral Health Coalition. The Oral Health Coalition hosted a priority policy meeting in 2010 which included many oral health advocates.				X
5. The Oral Health Program published Oral Health Program Accomplishments for 2010-2011. The document can be viewed at:				X

http://www.ndhealth.gov/oralhealth/Publications/Fact_Sheet_Accomplish2010-2011.pdf.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

• The State Oral Health program collaborated with Ronald McDonald House Charities Dental Care Mobile to provide services for children in underserved areas and link children to dental homes.
• The State Public Health Hygienists implemented the school-based sealant program, Seal!ND, to the students in schools that are at 50 percent or higher free and reduced lunch rates.
• The State Oral Health Program is collaborating with the Oral Health Coalition by providing education and/or information on their grant goals and objectives.
• The State Oral Health DentaQuest Grant initiative completed public forums and surveys to gauge public perceptions on oral health access. Survey results will be used to help write a targeted State Oral Health Plan. In addition, a Stakeholders Group met several times to review the data and provide input into the State Plan development.

c. Plan for the Coming Year

• The State Oral Health program will collaborate with various partners (e.g. Department of Public Instruction, school nurses, ND Oral Health Coalition, Dental Safety Net clinics, Dental Care Mobile) to expand the school-base sealant program, Seal!ND, to additional schools throughout the state.
• State Oral Health Program staff will collaborate with maternal and child health partners, Women, Infants and Children (WIC), Head Start and school nurses to incorporate oral health prevention messages to their clientele through educational presentations, displays, newsletters, etc.
• The State Oral Health Program will disseminate the results of the 2009-2010 Basic Screening Survey of third grade children through release of the 2012-2016 Oral Health Burden document and State Plan.
• Children's Special Health Services will provide payment for protective sealants for eligible children with special health care needs.
• The State Oral Health Program will continue to seek out funding opportunities for oral health prevention programs for children.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	5	3.6	3.5	3.4	3.1
Annual Indicator	3.7	3.5	3.2	3.8	3.8
Numerator	14	13	12	14	14
Denominator	374128	374128	378432	373047	373047
Data Source		See note field.	See note field.	See note field.	See note field.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over					

the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	3.6	3.4	3.2	3	2.8

Notes - 2011
2011-Final 2010 data was used as provisional data for 2011. A three-year total was used to calculate the rate to avoid fluctuations. The data for the numerator is from the North Dakota Department of Health -- Division of Vital Statistics. The denominator is from the 2010 U.S. Census from the U.S. Census Bureau, Population Division. Note: Prior to 2009 the source for demominator data was 2000 census.

Notes - 2010
2010- A three-year total was used to calculate the rate to avoid fluctuations. The data for the numerator is from the North Dakota Department of Health -- Division of Vital Statistics. The denominator is from the 2010 U.S. Census from the U.S. Census Bureau, Population Division. Note: Prior to 2009 the source for demominator data was 2000 census.

Notes - 2009
2009-A three-year total was used to calculate the rate to avoid fluctuations. The source for this data is the North Dakota Department of Health -- Division of Vital Statistics. The denominator is from the U.S. Census Bureau, Population Division, Vintage 2008 Population Estimates, Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: April 1, 2000 to July 1, 2009. Note-Prior to 2009 the source for demominator data was 2000 census.

a. Last Year's Accomplishments
The ND Department of Health (DoH) continues to receive funding from the ND Department of Transportation (NDDOT) to implement child passenger safety (CPS) programs and activities. Most of the funding is directed to children ages birth to 12 years of age. The goal of the program is to reduce injury and death due to motor vehicle crash events.

Data collected from car seat checkup forms conducted by the DoH statewide indicate that 87.8 percent of the car seats checked in 2010 had at least one error in use. Seventy-two percent of the car seats were installed wrong in the vehicle and 67 percent of the children were secured incorrectly in their restraint. The full report can be viewed at: www.ndhealth.gov/injuryprevention/childpassenger/publications/ChildPassengersatRisk.pdf

There was a not a significant change in death rates from 2009 (3.2) to 2010 (3.8). These numbers reflect a three-year average.

Program accomplishments within the 2011 federal fiscal year include:
• The CPS program received funding from the DOT for October 1, 2010 through September 30, 2011. Funds were used for CPS public information and education, trainings, car seat checkup supplies and car seats for the distribution programs. The program collaborated with Women, Infant and Children (WIC), public health, Head Start and Early Head Start, clinics, Safe Communities Coalitions, law enforcement, Safe Kids Coalitions and other agencies that work with caregivers who have contact with children.
• With DOT funds, the new CPS best practice information was put on brochures, displays, litter bags etc. and was distributed statewide. 2011 Safe Ride News Fact Sheets were purchased, printed and distributed. The materials were offered free to all agencies in the state.
• Sixty-nine local agencies statewide participated in CPS month activities. New CPS activity

booklets Ready? Safe? Go! for grades K-2 and 3-6 grades were created. The K-2 booklet can be viewed at: www.ndhealth.gov/injury/publications/NDDOH_K-2_kt.pdf. The 3-6 booklet can be viewed at: http://www.ndhealth.gov/injury/publications/NDDOH_3-6_kt.pdf. Evaluations received showed that 784 child passenger safety presentations were done in the classroom, 620 classrooms received materials only (with the teacher doing the presentation) with a total of 24,566 children reached through this campaign.
• With DOT funding, the ND CPS law fact sheet was updated to represent CPS best practices. The CPS law was included in the 2011 Ready? Safe? Go! activity booklets. The fact sheet can be viewed at: http://www.ndhealth.gov/injuryprevention/childpassenger/Info/cps%20law.pdf.
• DOT funds were used to purchase 1,843 car seats for the 40 car seat distribution programs in ND. Clients receiving a car seat received assistance on how to use the seat correctly. The program's policy and procedure manual was brought up to date and new educational DVD's were purchased and distributed to all programs.
• The CPS program assisted with 77 community car seat checks, inspecting 907 seats statewide.
• Four National Highway Traffic Safety Administration certification courses were offered in the state certifying 37 technicians in ND. ND has approximately 200 certified CPS technicians. Three recertification courses were offered to technicians for recertification purposes and ongoing technical assistance was offered to certified technicians for certification renewal. Six CPS trainings were offered to law enforcement training centers with 118 law enforcement personnel in attendance.
• Buckle Update newsletters were distributed quarterly. The newsletter addresses non-technical CPS updates for the public.
• The Division of Injury Prevention and Control was represented on the core planning committee formed to implement Graduated Driver's License (GDL) requirements for new teen drivers in ND. Through the efforts of the committee and others, the minor driver's license law was strengthened during the 2011 legislative session. A "No Texting" law for all ND drivers was also passed during the 2011 legislative session.
• The ND Injury Prevention Coalition is a collaboration of many different state and private injury prevention advocates. The coalition created the ND Injury Prevention Plan 2010 that includes prevention strategies for the reduction of motor vehicle crash fatalities. The plan can be viewed at: http://www.ndhealth.gov/injury.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The CPS program received funding from the DOT for October 1, 2010 through September 30, 2011. Funds were used for CPS public information and education, trainings, car seat checkup supplies and car seats for the distribution programs.		X		
2. With DOT funds, the new CPS best practice information was put on brochures, displays, litter bags etc. and was distributed statewide.		X		
3. Sixty-nine local agencies statewide participated in CPS month activities.		X		
4. With DOT funding, the ND CPS law fact sheet was updated to represent CPS best practices.		X		
5. DOT funds were used to purchase 1,843 car seats for the 40 car seat distribution programs in ND.		X		
6. The CPS program assisted with 77 community car seat checks, inspecting 907 seats statewide.		X		
7. Four National Highway Traffic Safety Administration certification courses were offered in the state certifying 37 technicians in ND.				X
8. Buckle Update newsletters were distributed quarterly. The		X		

newsletter addresses non-technical CPS updates for the public.				
9. The Division of Injury Prevention and Control was represented on the core planning committee formed to implement Graduated Driver's License (GDL) requirements for new teen drivers in ND.				X
10. The ND Injury Prevention Coalition is a collaboration of many different state and private injury prevention advocates. The coalition created the ND Injury Prevention Plan 2010.				X

b. Current Activities

• Two National Highway Traffic Safety Administration certification courses were offered, which certified 20 child passenger safety (CPS) technicians in ND.
• CPS Safe Ride News fact sheets were sent statewide to agencies who work with caregivers of young children (e.g., hospitals, public health, law enforcement etc.). New CPS best practice flyers and litter bags were also created and distributed.
• The CPS program continued to support and coordinate car seat checkups with multiple agencies statewide.
• CPS month was celebrated statewide in February. Approximately 68 agencies ordered CPS materials for distribution to schools. The campaign reached about 21,709 children.
• The CPS program updated the policy and procedure manual and provided training to staff.
• A representative from the Coordinated School Health team presented the Youth Risk Behavioral Survey (YRBS) data to the Injury Prevention and Control team.

c. Plan for the Coming Year

• Continue the contractual relationship with the ND Department of Transportation for funds to administer the state's child passenger safety (CPS) program activities; monitor expenditures and complete reports as required.
• Inform ND parents and caregivers about the state's CPS law. Create CPS best practice information (pamphlets, posters, displays, news releases, newsletters etc.) and distribute statewide to agencies that work with parents and caregivers to increase the use and proper use of car seats and seat belts.
• Participate in National CPS Week in September 2012. Sponsor CPS Month in February 2013 and encourage public health, law enforcement, Safe Kids Coalitions and other groups to participate in these efforts locally.
• Support the car seat distribution program throughout the state by providing car seats, policies/procedures and training/technical assistance to local programs.
• Assist local agencies in conducting car seat check-ups by providing certified instructors, technicians, car seats and check-up supplies.
• Conduct three National Highway Traffic Safety Administration (NHTSA) Standardized CPS Certification trainings to certify new CPS technicians and offer other CPS trainings to professionals including, hospital staff, law enforcement, etc. Conduct two to three recertification workshops/trainings for certified CPS technicians and assist technicians in meeting requirements for re-certification. On an ongoing basis, provide technical assistance and updated information to certified technicians to maintain technical knowledge on CPS issues.
• Write the "Buckle Update" section of the "Building Blocks to Safety" quarterly newsletter to provide current information on CPS.
• By using best practices, collaborate with partners that support efforts to strengthen occupant protection laws (e.g. graduated drivers license, child passenger safety and seat belt) to develop policies, provide education and promote safe driving.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	36	37	38	39	42
Annual Indicator	34.1	37.6	41.2	46.1	46.1
Numerator	10459	11531	3697	4189	4189
Denominator	30670	30670	8974	9088	9088
Data Source		See note field.	See note field.	See note field.	See note field.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	48	48.5	49	49.5	50

Notes - 2011
2011-Final 2010 data was used as provisional data for 2011. The source for 2010 data is the Center for Disease Control and Prevention National Immunization Survey, provisional data, 2008 births. The source for 2005, 2006 and 2007 data was the 2003 National Survey of Children's Health. The denominator used from 2008 onwards is the number of resident births in North Dakota. Note: The denominator for 2008 was changed from 30,670 reported in 2008 to 8,931. The source of the denominator is from the North Dakota Department of Health -- Division of Vital Statistics which represents the number of births for the calender year. The numerator is derived from back calculation.

Notes - 2010
2010-The source for 2010 data is the Center for Disease Control and Prevention National Immunization Survey, provisional data, 2008 births. The source for 2005, 2006 and 2007 data was the 2003 National Survey of Children's Health. The denominator used from 2008 onwards is the number of resident births in North Dakota. Note: The denominator for 2008 was changed from 30,670 reported in 2008 to 8,931. The source of the denominator is from the North Dakota Department of Health -- Division of Vital Statistics which represents the number of births for the calender year. The numerator is derived from back calculation.

Notes - 2009
2009-The new source for 2008 data is the Center for Disease Control and Prevention National Immunization Survey, provisional data, 2006 births. The source for 2005, 2006 and 2007 data was the 2003 National Survey of Children's Health. The denominator used from 2008 onwards is the number of resident births in North Dakota. The denominator for 2008 was changed from 30,670 reported in 2008 to 8,931. The source of the denominator is from the North Dakota Department of Health -- Division of Vital Statistics. The numerator is derived from back calculation.

a. Last Year's Accomplishments
According to the Center for Disease Control and Prevention (CDC) Breastfeeding Report Card (which uses the CDC National Immunization Survey data collected annually) in 2010, approximately 46 percent of ND mothers continue to breastfeed their infants at six months of age. During 2010, 20 percent of Women, Infants and Children (WIC) Program mothers continue to breastfeed their infants at six months of age. Both of these percentages fall well short of the HP 2020 goal of having 60.6 percent of all mothers breastfeeding their infants until at least six months of age.

Over the past 10 years, the percentage of mothers initiating breastfeeding in the total population appears to be leveling off at approximately 71 percent; again short of the 2010 goal of 75 percent. The numbers of WIC moms initiating breastfeeding, while gradually increasing over the same period, is just over 63 percent. Two areas of particular concern for ND WIC are the low numbers of American Indian mother who choose breastfeeding (49%) and WIC's over all very low breastfeeding duration rates, mentioned above (national WIC levels are 27% versus ND's 20%). Going back to school and work are the most commonly reported reasons for moms who stop breastfeeding.

Program accomplishments within the 2011 federal fiscal year include:
• State Maternal and Child Health (MCH), WIC, and Healthy Communities Nutritionists worked through the Healthy ND Breastfeeding Committee (HNDBC) using CDC's Communities Putting Prevention to Work grant funding to develop the breastfeeding support/infant friendly workplace designation program. Materials developed and provided for this program includes a ND infant friendly website; a brochure of guidelines for worksites/employers; workplace support for breastfeeding book marks displaying the state and federal laws; window clings that display the universal sign for breastfeeding; breastfeeding prescription pads for physicians; workplace support posters and display board; media campaigns and events; and offering The Business Case for Breastfeeding training to various partners. The ND Breastfeeding website can be viewed at: http://www.ndhealth.gov/breastfeeding.
• The state WIC Nutritionist continued acting as the ND Department of Health's (DoH) liaison to the HNDBC to lead member breastfeeding conference calls, encouraging updates and information sharing among local breastfeeding coalitions and members.
• State and local WIC, Optimal Pregnancy Outcome Program (OPOP) and MCH staff encouraged breastfeeding to prenatal clients as the optimal method of feeding healthy infants and provided breastfeeding support to breastfeeding moms through clinics and local community breastfeeding coalition activities.
• The state WIC Program supported breastfeeding by providing local agencies with resources for the promotion of World Breastfeeding Week in August; purchasing breast pumps (as funding permitted) for use by mothers who returned to work or school; provided Loving Support breastfeeding training to all WIC sites for updates on breastfeeding information and use with clients; encouraged and supported WIC staff in advanced breastfeeding trainings and conferences, and provided resources and technical assistance through the WIC recently formed breastfeeding committee. Breastfeeding support was also offered through the WIC Peer Counseling Program at three local WIC agencies; through "Why Breastfeed?" segment of the monthly WIC participant newsletter and by reinforcing nutrition messages and benefits related to the new WIC food packages aimed at increasing breastfeeding initiation and duration.
• State MCH and WIC Nutritionists encouraged local staff to pursue the development of local breastfeeding coalitions for information sharing, organized breastfeeding activities in their communities; to identify and promote community breastfeeding experts; and breastfeeding support groups as resources for breastfeeding mothers.
• The 2010 Worksite Wellness training included information/data from the statewide worksite survey which included questions about breastfeeding support in the worksite. This survey provided some data on current worksite practices, interest of employers and contact information for the future planning.
• State MCH and WIC staff maintained current breastfeeding data, disseminated information through email lists and placed it on the DoH's website.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. State Maternal and Child Health (MCH), WIC, and Healthy Communities Nutritionists worked through the Healthy ND Breastfeeding Committee to develop the breastfeeding				X

support/infant friendly workplace designation program.				
2. The state WIC Nutritionist continued acting as the ND Department of Health's (DoH) liaison to the HNDBC to lead member breastfeeding conference calls, encouraging updates and information sharing among local breastfeeding coalitions and members.				X
3. State and local WIC, Optimal Pregnancy Outcome Program (OPOP) and MCH staff encouraged breastfeeding to prenatal clients as the optimal method of feeding healthy infants.		X		
4. The state WIC Program supported breastfeeding by providing local agencies with resources for the promotion of World Breastfeeding Week in August.		X		
5. State MCH and WIC Nutritionists encouraged local staff to pursue the development of local breastfeeding coalitions.				X
6. The 2010 Worksite Wellness training included information/data from the statewide worksite survey which included questions about breastfeeding support in the worksite.				X
7. State MCH and WIC staff maintained current breastfeeding data, disseminated information through email lists and placed it on the DoH's website.				X
8.				
9.				
10.				

b. Current Activities

• The guidelines for becoming an Infant Friendly Worksite were complete and placed on the Department of Health's (DoH) breastfeeding website. Twenty-six businesses have been recognized for their efforts to support breastfeeding in the workplace.
• Breastfeeding data was updated and disseminated to partners through the DoH's breastfeeding website.
• Local Women, Infants and Children (WIC) and Optimal Pregnancy Outcome Program (OPOP) staff educated prenatal clients in breastfeeding and promoted it as the optimal method of feeding healthy infants while providing support to all breastfeeding moms.
• The State Maternal and Child Health (MCH) and WIC Nutritionists support local program staff by providing breastfeeding resources, encouraging participation in breastfeeding training and conferences, and by providing technical assistance to all local partners.
• The state WIC Nutritionist supports breastfeeding by purchasing breast pumps (as funding permits), supports participation in breastfeeding trainings and provides resources and technical assistance to local staff.

c. Plan for the Coming Year

• State and local Women Infants and Children (WIC), Optimal Pregnancy Outcome Program (OPOP) and Title V Maternal and Child Health (MCH) Nutrition staff will educate prenatal clients on breastfeeding, promote it as the optimal method of feeding healthy infants and provide support to all breastfeeding moms.
• The State MCH Nutritionist will monitor and coordinate activities of the ND Department of Health's (DoH) infant friendly worksite recognition initiative.
• The State MCH Nutritionist will act as the DoH liaison to the Healthy ND Breastfeeding Committee.
• The State MCH Nutritionist will facilitate the statewide breastfeeding coalition quarterly calls and activities.
• State MCH and WIC Nutritionists will encourage local staff to pursue the development of local breastfeeding coalitions and identify and promote community breastfeeding experts and support groups as a support resource for breastfeeding mothers.

• The State MCH Nutritionist will help support the planning activities for the statewide breastfeeding conference and work with the State WIC Nutritionist to encourage local staff to participate in all available breastfeeding conferences and trainings.
• The State WIC Nutritionist will support breastfeeding by providing breastfeeding resources, encouraging participation in breastfeeding training and conferences, and by providing technical assistance to all local WIC staff and agencies.
• State Title V staff will maintain current breastfeeding data, with input from the State WIC Breastfeeding Coordinator and disseminate information through mailings and on the DoH's breastfeeding website (e.g., Parenting The First Year Magazine, New Mother Fact Sheets, The Birth Review Program, etc).

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	97	98	98	98	98
Annual Indicator	95.0	94.3	97.9	97.9	97.9
Numerator	9386	9545	10094	10251	10251
Denominator	9875	10118	10313	10470	10470
Data Source		See note field.	See note field.	See note field.	See note field.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	98.1	98.2	98.3	98.4	98.5

Notes - 2011
2011-Final 2010 data was used as provisional data for 2011. Data was obtained from the 2009 Newborn Hearing Screening Survey Report, which was collected in 2010.

Notes - 2010
2010-Data was obtained from the 2009 Newborn Hearing Screening Survey Report, which was collected in 2010.

Notes - 2009
2009-Data was obtained from the 2008 Newborn Hearing Screening Survey Report, which was collected in 2009.

a. Last Year's Accomplishments
The ND Early Hearing Detection and Intervention (EHDI) program continues to focus on reducing the number of infants that are lost to follow-up. The program worked closely with Right Track, Early Intervention staff and audiologists to have results entered into the EHDI tracking system. The ND Center for Persons with Disabilities (NDCPD) received a federal Maternal and Child Health Bureau EHDI grant for the time period of 4/01/2011 to 3/31/2014. NDCPD also received a Center for Disease Control and Prevention Early Hearing Detection and Intervention Information System (EHDI-IS) Surveillance Program grant. The grant is intended to enhance electronic

system capacity to collect data, ensure children receive recommend screening and follow-up services, and exchange data accurately, effectively, securely, and consistently between the EHDI-IS and Electronic Health Record Systems with a specific focus on reducing the duplicate data entry burden and a reduction in loss to recommended follow-up services (screening, diagnosis, and intervention).

In 2010, ND achieved a birth screen rate of 98 percent compared to a rate of 39 percent in 2000. Ten percent of all infants were referred for additional testing, of which 70 percent had a documented retest. ND continues to have difficulty confirming the actual number of infants that have a confirmed hearing loss.

Program accomplishments within the 2011 federal fiscal year include:
• A state Children's Special Health Services (CSHS) staff member served on the grant management team of the state's EHDI Program administered through the NDCPD at Minot State University. The staff member also functioned as the state implementation coordinator. Work efforts during the year focused on reducing the number of infants lost to follow-up and promoting EHDI program sustainability.
• In CY 2010, 98 percent of newborns born in ND received a hearing screening. This information is collected through OZ eSP, a web-based data tracking system.
• Vital Records data for CY 2010 was collected and compiled. The data was compared to the web-based data tracking system. The reasons why the screenings were not done were also reviewed.
• A CSHS staff member served as the Title V state EHDI contact. During the year, the EHDI contact responded to state and national survey requests and was an information hub for any new information relating to EHDI programs.
• CSHS staff promoted data integration activities between newborn hearing screening and vital records. Minot State University, the CDC EHDI Data Linkage grantee, updated the Data Use Agreement between NDCPD and Vital Records. NDCPD received monthly Vital Records data, which through the use of a data linkage program linked the two data sets using multiple matching fields. The records that could not be matched were given to the EHDI team to follow-up with the hospitals in order to identify which births were missing in the database but were reported to Vital Records.
• In an effort to reduce the number of infants that are lost to follow-up, ND EHDI used state general funds to purchase a Provider Access Tool module for the OZ eSP web-based tracking system.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. A state Children's Special Health Services (CSHS) staff member served on the grant management team of the state's EHDI Program administered through the NDCPD at Minot State University.				X
2. In CY 2010, 98 percent of newborns born in ND received a hearing screening. This information is collected through OZ eSP, a web-based data tracking system.			X	
3. Vital Records data for CY 2010 was collected and compiled. The data was compared to the web-based data tracking system. The reasons why the screenings were not done were also reviewed.				X
4. A CSHS staff member served as the Title V state EHDI contact. During the year, the EHDI contact responded to state and national survey requests and was an information hub for any new information relating to EHDI programs.				X
5. CSHS staff promoted data integration activities between				X

newborn hearing screening and vital records.				
6. In an effort to reduce the number of infants that are lost to follow-up, ND EHDI used state general funds to purchase a Provider Access Tool module for the OZ eSP web-based tracking system.				X
7.				
8.				
9.				
10.				

b. Current Activities

• A Children's Special Health Services (CSHS) staff member is serving on the grant management team and functions as the state coordinator for the Early Hearing Detection and Intervention (EHDI) Program.
• CSHS monitors the status of newborn hearing screening and those lost to follow-up at all birthing hospitals in the state.
• CSHS monitors data integration activities between newborn hearing screening, newborn blood spot screening, immunizations, and vital records in partnership with Minot State University.
• CSHS is evaluating the use of the OZ eSP Provider Access Tool.

c. Plan for the Coming Year

• A Children's Special Health Services (CSHS) staff member will serve on the North Dakota Center for Persons with Disabilities grant management team and function as the state coordinator for the Early Hearing Detection and Intervention (EHDI) Program. ND efforts will focus on reducing infants lost to follow-up, border babies, data entry issues in western ND, data linkage, the National Initiative for Child Health Quality (NICHQ) learning collaborative project, and sustainability.
• CSHS will promote the use of the new OZ eSP Provider Access Tool.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	8.5	9.5	9	9.8	6.8
Annual Indicator	10.0	10.0	7.0	8.1	8.1
Numerator	16085	16085	11000	12140	12140
Denominator	160849	160849	157142	149871	149871
Data Source		See note field.	See note field.	See note field.	See note field.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	7.8	7.6	7.4	7.2	7

Notes - 2011
2011-Final 2010 data was used as provisional data for 2011. The sources for this data are the 2010 Kids Count and the U.S. Census Bureau. The numerator is derived from a back calculation that applies the percent of children without health insurance from Kids Count to the denominator of children birth through 17 from the 2010 census. Note: Prior to 2009, the source for demominator data was 2000 census. In 2009, census estimates were used.

Notes - 2010
2010- The sources for this data are the 2010 Kids Count and the U.S. Census Bureau. The numerator is derived from a back calculation that applies the percent of children without health insurance from Kids Count to the denominator of children birth through 17 from the 2010 census. Note: Prior to 2009, the source for demominator data was 2000 census. In 2009, census estimates were used.

Notes - 2009
2009-The sources for this data are the 2009 Kids Count .The denominator is derived from back calculation. The source of numerator is from the KIDS COUNT data center.Note-Prior to 2009 the source for demominator data was 2000 census.

a. Last Year's Accomplishments
The percent of children in ND without health insurance varies slightly depending on the data source, but generally has a range of 8.0 to 9.0 percent.

The 2008-2010 three-year average of uninsured children in ND was approximately 12,000 children, which is roughly equivalent to one out of every 12 children in the state. Small sample sizes can cause state estimates to fluctuate widely year-to-year, so a three-year average estimate was used. For 2011, the ND State Data Center reported 8.1 percent of children ages 0 to 17 as uninsured using a three-year average estimate for 2008-2010. Nationally, 9.9 percent of children were without health insurance coverage. ND's rate of uninsured children ranked in the middle of the 50 states. When examining the two-year averages between 2008-09 and 2009-10 for ND, it appears that the proportion of uninsured children in our state increased by 1.2 percent. However, because of the small sample size, this amount of change is not statistically significant. In 2010, the Kaiser Foundation reported eight percent of ND children were uninsured for the years 2009-2010 compared to 10 percent in the nation. The 2007 National Survey of Children's Health reported 91.6 percent of ND children were currently insured (8.4% uninsured) compared to the national average of 90.9 percent (9.1% uninsured). The 2009-2010 National Survey of Children with Special Healthcare Needs reported 7.3 percent of ND children with special healthcare needs were without insurance at some point during the past year compared to 9.3 percent in the nation.

Children's Special Health Services (CSHS) monitored whether children served had a source of health care coverage. In Federal Fiscal Year 2010, 91 percent of children with special health care needs served by CSHS had a source of health care coverage; 59.1 percent of these children were covered by private insurance.

Medicaid and Healthy Steps, ND's Children's Health Insurance Program, have been effective public programs in reducing the number of uninsured, low-income children in the state. For SFY 2010, there were a total of 84,529 Medicaid recipients compared to 77,637 in SFY 2009. Of that group, 72.4 percent were Caucasian, 22.4 percent were American Indian, 4.2 percent were Black, 0.9 percent were Asian/Pacific Islander, and 0.1 percent were other. Of the 84,529 total recipients, 49,110 or 58.1 percent were zero through 20 years of age. Of the 49,110 recipients birth through 20 years of age, 25.2 percent were 0 through 5 years of age, 29.1 percent were 6 through 18 years of age and 3.8 percent were 19 through 20 years of age. In 2009, of the 77,637 recipients, 44,333 or 57.1 percent were zero through 20 years of age.

Program accomplishments within the 2011 federal fiscal year include:

• CSHS collaborated through FamNet, Early Childhood Comprehensive Systems Program and Medical Services in advocating for children's health insurance coverage.
• WIC staff received updates on health insurance options for children (such as Medicaid, Healthy Steps and the Caring for Children Program). CSHS actively sought out information regarding coverage options and distributed updates to various groups, including families.
• The State School Nurse Consultant distributed health insurance information to nurses through the use of the statewide listserv.
• Title V staff participated in the June 2011 ND Healthy Steps annual meeting to discuss opportunities to connect uninsured children with health coverage.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. CSHS collaborated through FamNet, Early Childhood Comprehensive Systems Program, and Medical Services in advocating for children's health insurance coverage.				X
2. WIC staff received updates on health insurance options for children. CSHS actively sought out information regarding coverage options and distributed updates to various groups, including families.		X		
3. The State School Nurse Consultant distributed health insurance information to nurses through the use of the statewide listserv.		X		
4. Title V staff participated in the June 2011 ND Healthy Steps annual meeting to discuss opportunities to connect uninsured children with health coverage.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
• Title V, Family Planning and Women, Infant and Children (WIC) staff are collaborating with advocacy partners to increase children's health insurance coverage.
• Title V, Family Planning and WIC staff are staying informed about current health insurance options for children and distributing information to various groups.
• Health insurance coverage options have been printed in various publications (e.g., Parenting The First Year magazine, Health Care Coverage brochure, Financial Help packet).

c. Plan for the Coming Year
• State Title V, Family Planning and Women, Infants and Children (WIC) staff will collaborate with partners in advocacy for increasing children's health insurance coverage.
• State Title V, Family Planning and WIC staff will stay informed of current health insurance options for children and distribute information to various groups including families, school nurses, county social service staff, local public health, childcare providers, etc. and refer as appropriate.
• State Title V staff will continue to participate in the ND Healthy Steps annual meetings to determine future opportunities to connect uninsured children with health coverage.
• State Title V staff will disseminate information on health insurance coverage options (i.e., Parenting The First Year Magazine, Health Care Coverage brochure, Financial Help packet).

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	29	28.5	28	31	30.8
Annual Indicator	29.8	31.3	31.6	30.9	30.9
Numerator	1588	2050	2201	2112	2112
Denominator	5330	6551	6968	6836	6836
Data Source		See note field.	See note field.	See note field.	See note field.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	30.6	30.4	30.2	30	28.8

Notes - 2011
2011-Final 2010 data was used as provisional data for 2011. The source for this data is from the 2010 Pediatric Nutrition Surveillance System (PedNSS), which is conducted every two years.

Notes - 2010
2010-The source for this data is from the 2010 Pediatric Nutrition Surveillance System (PedNSS), which is conducted every two years.

Notes - 2009
2009-The source for this data is from the 2009 Pediatric Nutrition Surveillance System (PedNSS), which is conducted every two years.

a. Last Year's Accomplishments
The 2010 Women, Infants and Children Program (WIC) data showed that 31 percent of ND WIC children two years of age and older have a Body Mass Index (BMI) of 85 percent or greater. The Center for Disease Control and Prevention (CDC) categorizes 85th -<95th percentile as children "at risk of overweight" and those at the 95th percentile and above as "overweight." The 31 percent is double the number that should be expected in a normal distribution. ND percentages are almost identical to the national WIC numbers. CDC BMI for age estimates that only five percent of children should be above the 95th percentile (ND is 14.1%) and 10 percent between the 85th and 95th (ND is 16.8%). While the trend is a concern for all ND WIC children, it is of particular concern for American Indian children who are more likely to be overweight and at risk of overweight (42%) than the state average. Looking at the past 10 years, the rapid increase in overweight among all ND WIC children seems to be leveling off, but among American Indian children, the numbers continue to increase.

Program accomplishments within the 2011 federal fiscal year include:
• State WIC staff continued the WIC newsletter, "The Pick-WIC Paper" that included the topic areas of "Why Breastfeed?" to promote breastfeeding, "Turn Off the TV" to promote physical activity ideas for young children and the new "Shop Smart: Stretch Your Fruit and Veggie Dollar"

to help families in purchasing fresh fruit and vegetables which all help to enforce healthy choices to promote healthy families.
• State WIC staff encouraged local staff to continue using Motivational Interviewing (MI) techniques for obtaining more rich and meaningful information from participants, for completing risk assessments, care plans, counseling and information sharing with participants. Local WIC staff also educated and encouraged WIC families to make low fat milk choices.
• Local WIC staff collected body mass index (BMI) information on all participants and provided nutrition and physical activity education and counseling, along with referrals as appropriate.
• State and local WIC staff developed specific nutrition education resource cards and monthly education materials focusing on nutrition and physical activity messages and recipes for WIC participants.
• WIC provided tailored food packages and personalized nutrition education after making thorough nutrition risk assessments and made referrals to appropriate health care providers for additional services as needed.
• MCH, WIC and Healthy Communities (HC) staff helped support efforts to increase physical activity in the child care setting by promoting the newly revised state child care licensing regulations that addressed limited television, video and computer time. They also worked to inform child care providers about new physical activity education offerings that can be used in completing the requirements for the Child Development Associate Credential. MCH and HC nutritionists served on the Physical Activity in Child Care Advisory Committee formed as part of the Communities Putting Prevention to Work (CPPW) grant funding. The advisory committee is made up of members from child care resource and referral, early childhood programs, various Health and Human Service departments as well as child care providers. Activities of the committee included putting together a best practices document for physical activity in child care, a "Move, Play, and Learn" CD on physical activity for child care providers and a media campaign with online, radio and TV ads promoting physical activity in child care settings.
• The state MCH Nutritionist encouraged local public health staff to work with child care providers, farmers markets, community gardens and community recreational programs to teach and promote families to grow their own food, make healthy food choices, to become more physically active and more proactive in their daily choices for wellness.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. State WIC staff continued the WIC newsletter that included “Why Breastfeed?”, “Turn Off the TV” and the new “Shop Smart: Stretch Your Fruit and Veggie Dollar."		X		
2. State WIC staff encouraged local staff to continue using Motivational Interviewing (MI) techniques.				X
3. Local WIC staff collected body mass index (BMI) information on all participants and provided nutrition and physical activity education and counseling, along with referrals as appropriate.		X		
4. State and local WIC staff developed specific nutrition education resource cards and monthly education materials focusing on nutrition and physical activity messages and recipes for WIC participants.		X		
5. WIC provided tailored food packages and personalized nutrition education after making thorough nutrition risk assessments and made referrals to appropriate health care providers for additional services as needed.		X		
6. MCH, WIC and Healthy Communities (HC) staff helped support efforts to increase physical activity in the child care setting by promoting the revised state child care licensing regulations that addressed limited television, video, and				X

computer time.				
7. The state MCH Nutritionist encouraged local public health to work with various entities to teach and promote families to become more physically active and more proactive in their daily choices for wellness.				X
8.				
9.				
10.				

b. Current Activities

• State Women, Infants and Children (WIC) staff developed specific educational material on nutrition and physical activity for participants.
• Local WIC staff provides participants centered services through nutrition assessments (including BMI), food packages, nutrition education and counseling and referrals.
• The state Maternal and Child Health Nutritionist supports efforts to improve physical activity and nutrition in early childhood by serving as the facilitator on the Nutrition and Physical Activity in Early Childhood Committee.

c. Plan for the Coming Year

• State Women, Infants and Children (WIC) staff will continue informative segments on nutrition and physical activity topic areas in the monthly ND WIC participant newsletter.
• WIC will continue to conduct nutrition risk assessments, provide tailored food packages, personalized nutrition education and make referrals as needed.
• State and local WIC staff will continue to develop specific educational nutrition and physical activity resources and recipes for WIC participants.
• Local WIC staff will collect body mass index (BMI) information on participants and provide education or counseling, as appropriate.
• Local WIC staff will be encouraged to continue using Motivational Interviewing (MI) techniques and will be observed using them during state staff onsite monitoring visits.
• Local WIC staff will continue to educate and encourage WIC families to make low fat milk choices, consume whole grain foods and drink appropriate amounts of fruit and vegetable juices.
• The State Title V Maternal and Child Health (MCH) Nutritionist will support efforts to increase physical activity in the child care setting by serving as the facilitator on the Physical Activity in Child Care Committee.
• The State MCH Nutritionist will encourage local public health staff to work with childcare providers, farmers markets and community gardens to promote families to grow their own food, make healthy food choices and be physically active.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	14.2	14	13.8	13.5	12.8
Annual Indicator	14.8	14.1	13.0	12.9	12.9
Numerator	1306	1259	1170	1172	1172
Denominator	8807	8931	8974	9088	9088
Data Source		See note field.	See note field.	See note field.	See note field.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the					

last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	12.6	12.4	12.2	12	11.8

Notes - 2011
2011-Final 2010 data was used as provisional data for 2011. The source for this data is the North Dakota Department of Health, Division of Vital Statistics.

Notes - 2010
2010-The source for this data is the North Dakota Department of Health, Division of Vital Statistics.

Notes - 2009
2009-The source for this data is the North Dakota Department of Health, Division of Vital Statistics.

a. Last Year's Accomplishments
According to ND's Vital Records, the percentage of women who smoked during the last three months of pregnancy was 12.9 percent in 2010. Since 2007 (14.8 %), this percentage has continued to decline annually; a decrease of 1.9 percent.

Program accomplishments within the 2011 federal fiscal year include:
• The Tobacco Prevention and Cessation Program conducted research on the relation of Sudden Infant Death Syndrome (SIDS) and secondhand smoke. As a result of the research, a contractor was hired to develop media ads to increase awareness to the public of the increased risk of SIDS related to secondhand smoke. Production included one television ad, one radio ad, some online advertising and an article specific to tribal newspapers. The television and radio ads can be viewed at: http://www.ndhealth.gov/tobacco/SIDS-SecondhandSmoke.htm.
• The Tobacco Program continued to support the Baby & Me Tobacco Free Cessation Grant Program which provides tobacco cessation counseling to pregnant women and addresses relapse prevention by providing voucher of diapers for each month the mother remains tobacco free after delivery (for up to one year).
• The local Women Infants and Children (WIC), Optimal Pregnancy Outcome Program (OPOP), Cribs for Kids and Family Planning Program's delegate agency staff educated clients about the importance of not smoking and referred clients to cessation services, as appropriate.
• The State WIC staff posted the Centers for Disease Control and Prevention (CDC) Prenatal Nutrition Surveillance System information containing the smoking behaviors of women, before, during and after pregnancy, on the state WIC website pages.
• Local Tobacco Cessation Coordinators, Title V, Family Planning, OPOP and WIC staff used culturally appropriate educational materials geared towards pregnant smoking women with information on the ND Quitline and QuitNet.
• As a requirement of the Abortion Control Law, a Pregnancy and Abortion booklet is being developed. Information regarding the harmful efforts of tobacco use and secondhand smoke, along with information on the ND Quitline and QuitNet, are included in the booklet. Information on quitting smoking is also provided in Parenting The First Year magazine.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. A media ad was developed to increase awareness to the		X		

public of the increased risk of SIDS related to secondhand smoke.				
2. The Tobacco Program continued to support the Baby & Me Tobacco Free Cessation Grant Program which provides tobacco cessation counseling to pregnant women.				X
3. The local Women Infants and Children (WIC), Optimal Pregnancy Outcome Program (OPOP), Cribs for Kids and Family Planning Program's delegate agency staff educated clients about the importance of not smoking and referred clients to cessation services.		X		
4. The State WIC staff posted the Centers for Disease Control and Prevention (CDC) Prenatal Nutrition Surveillance System information containing the smoking behaviors of women, before, during and after pregnancy, on the state WIC website pages.				X
5. Local Tobacco Cessation Coordinators, Title V, Family Planning, OPOP and WIC staff used culturally appropriate educational materials geared towards pregnant smoking women with information on the ND Quitline and QuitNet.		X		
6. As a requirement of the Abortion Control Law, a Pregnancy and Abortion booklet is being developed. Information regarding the harmful efforts of tobacco use and secondhand smoke, along with information on the ND Quitline and QuitNet, are included.				X
7.				
8.				
9.				
10.				

b. Current Activities

• State Title V staff continues to collaborate with the Tobacco Prevention Program by expanding the media campaign related to reducing the risk of SIDS and preventing smoking during and after pregnancy.
• State Title V staff collaborates with partners such as Family Planning, Optimal Pregnancy Outcome Program (OPOP) and Women, Infants & Children (WIC) to continue to educate clients on the importance of not smoking and refer as needed.
• The Tobacco Prevention and Control Program revealed a new name, logo and website for the state's tobacco cessation program, NDQuits. NDQuits is a program that offers multiple ways to help tobacco users quit using tobacco.

c. Plan for the Coming Year

• The local Women Infants and Children (WIC), Optimal Pregnancy Outcome Program (OPOP), Cribs for Kids and Family Planning Program's delegate agency staff will educate clients about the importance of not smoking and refer to cessation services, as appropriate.
• Local OPOP staff will provide education, information and anticipatory guidance regarding smoking and pregnancy. Information shared will include local smoking cessation programs and reduction strategies, effects of tobacco on the fetus and other associated risks of tobacco use to clients, as appropriate.
• OPOP will continue to partner with Tobacco Prevention and Cessation to target tobacco prevention during and after pregnancy.
• Local Tobacco Cessation Coordinators, Title V, Oral Health, Family Planning, OPOP and WIC staff will use culturally appropriate educational materials geared towards pregnant smoking women including information on NDQuits.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	9.8	19.8	19	17.2	15
Annual Indicator	19.9	14.9	15.3	20.0	20.0
Numerator	32	24	24	30	30
Denominator	160854	160854	156452	150218	150218
Data Source		See note field.	See note field.	See note field.	See note field.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	19	18	17	16	15

Notes - 2011
2011-Final 2010 data was used as provisional data for 2011. The source for this data is the North Dakota Department of Health -- Division of Vital Statistics. The denominator is from the 2010 census conducted by U.S. Census Bureau, Population Division. Note: Prior to 2009, the source for demominator data was 2000 census. Please note corrections to 2003, 2004 & 2008 reporting: 2003 Annual Indicator: 8.7, Numerator: 14, Denominator: 160,854. 2004 Annual Indicator:12.4, Numerator: 20, Denominator: 160,854. 2008 Annual Indicator:14.9, Numerator: 24, Denominator: 160,854.

Notes - 2010
2010-The source for this data is the North Dakota Department of Health -- Division of Vital Statistics. The denominator is from the 2010 census conducted by U.S. Census Bureau, Population Division. Note: Prior to 2009, the source for demominator data was 2000 census. Please note corrections to 2003, 2004 & 2008 reporting: 2003 Annual Indicator: 8.7, Numerator: 14, Denominator: 160,854. 2004 Annual Indicator: 12.4, Numerator: 20, Denominator: 160,854. 2008 Annual Indicator: 14.9, Numerator: 24, Denominator: 160,854.

Notes - 2009
2009-The source for this data is the North Dakota Department of Health -- Division of Vital Statistics. The denominator is from the U.S. Census Bureau, Population Division, Vintage 2008 Population Estimates, Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: April 1, 2000 to July 1, 2009. Note-Prior to 2009 the source for demominator data was 2000 census. Please note corrections to 2003, 2004 & 2008 reporting: 2003 Annual Indicator: 8.7, Numerator: 14, Denominator: 160,854. 2004 Annual Indicator: 12.4, Numerator: 20, Denominator: 160,854. 2008 Annual Indicator: 14.9, Numerator: 24, Denominator: 160,854.

a. Last Year's Accomplishments
According to ND Vital Records data, the youth suicide rate was 31.6 per 100,000. This is an increase from the youth deaths in 2009, which was at a rate of 20.35 per 100,000. In 2010, there were 15 people in ND between the ages of 15 through19 that died by suicide. In 2009, 10 people

between the ages of 15 through19 died by suicide. Three-year data trends continue to show an increase. In 2010, the three-year average was 20, compared to 15.3 in 2009.

Program accomplishments within the 2011 federal fiscal year include:
• Approximately 1 million dollars of general funds were authorized for the State Suicide Prevention Program during the 2011 legislative session.
• The State Suicide Prevention director continued to participate in the ND Suicide Prevention Coalition. The Coalition continued work on developing and implementing the state plan.
• The State Suicide Prevention Program assembled a task force of existing and new partners, in addition to the Coalition, with the purpose to develop a statewide survey looking at strengths and needs for suicide across the state.
• The State Suicide Prevention Program attended monthly staff meetings with the Maternal and Child Health (MCH) programs to provide an opportunity to share program developments and collaborate on upcoming projects.
• The State Suicide Prevention Program worked with an agency to promote media messaging via television and radio that suicide is preventable. The Suicide Prevention Program also worked with the Department of Human Services and the Out Of the Darkness walk committee to develop and promote billboards and fliers for the promotion of treatment for mental health and suicide.
• In September 2011, the State Suicide Prevention Program developed a news release and Governor's proclamation for suicide prevention month.
• The State Suicide Prevention Program continued several community grants within this time frame. The projects that ended included: 1) a grant to First Link to conduct an Applied Suicide Intervention Skills Training (ASIST) training within the state, 2) a grant to Northern Lights SADD (Students Against Destructive Decisions) to conduct a media buy to promote suicide awareness and to develop new radio and television ads geared towards the youth population, 3) a grant to the Mental Health Association of ND (MHAND) to send two trainers to a national train the trainer ASIST to support infrastructure within the state of ND, and 4) a grant to Northern Lights SADD to conduct a one day training for advisors on suicide prevention. The Suicide Prevention Program also provided new grants to: 1) FirstLink to conduct three more ASIST trainings throughout the state, 2) The Village to hold a suicide awareness walk within a local community, 3) Northern Lights SADD to develop radio and TV ads designed for youth by the youth leaders, and 4) MHAND to conduct two summits within ND to on standards of reporting suicide across the state.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Approximately 1 million dollars of general funds were authorized for the State Suicide Prevention Program during the 2011 legislative session.				X
2. The State Suicide Prevention director continued to participate in the ND Suicide Prevention Coalition. The Coalition continued work on developing and implementing the state plan.				X
3. The State Suicide Prevention Program assembled a task force of existing and new partners, in addition to the Coalition, with the purpose to develop a statewide survey looking at strengths and needs for suicide across the state.				X
4. The State Suicide Prevention Program attended monthly staff meetings with the Maternal and Child Health (MCH) programs to provide an opportunity to share program developments and collaborate on upcoming projects.				X
5. The State Suicide Prevention Program worked with an agency to promote media messaging via television and radio that suicide is preventable.		X		
6. In September 2011, the State Suicide Prevention Program		X		

developed a news release and Governor's proclamation for suicide prevention month.				
7. The State Suicide Prevention Program continued several community grants.				X
8.				
9.				
10.				

b. Current Activities

• Educational agencies received contracts through the State Suicide Prevention Program to teach bullying prevention and/or life skills to students.
• Educational agencies received contracts through the State Suicide Prevention Program to provide free suicide prevention training to high school teachers.
• A statewide suicide survey of agencies was completed by the State Suicide Prevention Program to assess current suicide prevention efforts.
• Children's Special Health Service's (CSHS) covers services to treat depression when it is related to the child's primary eligible condition and funds psychological assessments in several CSHS-sponsored multidisciplinary clinics.

c. Plan for the Coming Year

• The State Suicide Prevention Program director will continue to participate in the ND Suicide Prevention Coalition to address suicide efforts statewide.
• The State Suicide Prevention Program director will continue to work to implement depression screening and suicide assessment in primary care settings.
• The State Suicide Prevention Program director will continue suicide awareness, suicide education and early intervention programs for various occupational groups such as military, law enforcement, school teachers, coaches, university staff, nurses and emergency medical services personnel.
• The State Suicide Prevention Program director will continue to collaborate with statewide partners such as the Indian Affairs Commission, American Foundation for Suicide Prevention, Department of Human Services as well as various Title V programs to disseminate appropriate educational materials and messages for suicide prevention.
• The State Suicide Prevention Program will work with FirstLink to offer call back services for ND citizens calling the National Suicide Prevention Lifeline, or for citizens being referred to the Lifeline from professionals in the community.
• The State Suicide Prevention Program will continue to support widespread Applied Suicide Intervention Skills Training (ASIST) trainings throughout ND, for people that may be able to offer early intervention to those experiencing suicidal thoughts.
• The State Suicide Prevention Program will continue to work with local and tribal organizations in offering grant opportunities to support suicide prevention efforts.
• The Coordinated School Health (CSH) director will participate in the Youth Suicide Prevention Community of Practice Group.
• The CSH Program will continue to disseminate information on bullying and suicide prevention to an educator Listserv.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	48.5	54	55	46	52
Annual Indicator	53.9	45.1	50.9	52.4	52.4
Numerator	55	51	57	54	54

Denominator	102	113	112	103	103
Data Source		See note field.	See note field.	See note field.	See note field.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	52.5	53	53.5	54	54.5

Notes - 2011
2011-Final 2010 data was used as provisional data for 2011. The source for this data is the North Dakota Department of Health -- Division of Vital Statistics. The Level 3 facilities in the state, based on self-report, are Sanford in Fargo, St. Alexius in Bismarck, Medcenter One in Bismarck, Altru in Grand Forks and Trinity Hospital in Minot.

Notes - 2010
2010-The source for this data is the North Dakota Department of Health -- Division of Vital Statistics. The Level 3 facilities in the state, based on self-report, are Sanford in Fargo, St. Alexius in Bismarck, Medcenter One in Bismarck, Altru in Grand Forks and Trinity Hospital in Minot.

Notes - 2009
2009-The source for this data is the North Dakota Department of Health -- Division of Vital Statistics. The Level 3 facilities in the state, based on self-report, are Sanford in Fargo, St. Alexius in Bismarck, Medcenter One in Bismarck and Altru in Grand Forks.

a. Last Year's Accomplishments
According to ND Vital Records data, the percent of very low birth weight infants delivered at facilities for high-risk infants in 2010 was 52.4 percent. This percentage has increased over the last two years from 45.1 in 2008 and 50.9 percent in 2009.

Program accomplishments within the 2011 federal fiscal year include:
• A Connection for Families and Agencies: Resources for ND Families with Young Children Ages Birth ~ 8 continued to be available on the Department of Health's website and distributed as requested. This resource includes a listing of ND hospitals and nurseries with various NICU levels. The publication can be viewed at:
http://www.ndhealth.gov/familyhealth/publications/Connection%20Directory.pdf.
• Various programs (i.e., Women's, Infant and Children, Optimal Pregnancy Outcome Program, Family Planning) continued to provide education on topics that aim to reduce the chances of having a low birth weight baby. Referrals were made as appropriate.
• Title V staff monitored the percent of very low birth weight babies to gain insight as to the current needs in ND.
• Title V staff collaborated with other maternal and infant health partners through the Birth Review Program. This program fosters interdepartmental and interagency partnerships to identify, inform and refer at risk families for appropriate services.
• Title V staff participated in the Women's Partnership for Tobacco Prevention and Cessation for Women of Reproductive Age.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. A Connection for Families and Agencies: Resources for ND Families with Young Children Ages Birth – 8 continued to be available on the Department of Health's website and distributed as requested.		X		
2. Various programs (i.e., Women, Infants and Children, Optimal Pregnancy Outcome Program, Family Planning) continued to provide education on topics that aim to reduce the chances of having a low birth weight baby. Referrals were made as appropriate.		X		
3. Title V staff monitored the percent of very low birth weight babies to gain insight as to the current needs in ND.				X
4. Title V staff collaborated with other maternal and infant health partners through the Birth Review Program. This program fosters interdepartmental and interagency partnerships to identify, inform and refer at risk families for appropriate services.				X
5. Title V staff participated in the Women's Partnership for Tobacco Prevention and Cessation for Women of Reproductive Age.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

• A Connection for Families and Agencies: Resources for ND Families with Young Children Ages Birth ~ 8 is available on the Department of Health's website. This directory provides information including ND Hospital Neonatal Intensive Care Unit (NICU) levels.
• State Title V staff works with partners through the Birth Review Program to identify, inform and refer newborns at risk and provide connections with proper services.
• State Title V staff partners with the Tobacco Prevention and Control Program to provide information regarding smoking during pregnancy and health promotion for infants.
• Programs such as the Optimal Pregnancy Outcome Program and (OPOP) and Women, Infants and Children (WIC) provides education to clients on decreasing the risk of low birth weight infants.
• State Title V staff met with the March of Dimes to begin dialogue on collaborative efforts to improve infant health outcomes.
• The State Health Officer signed ASTHO's President's Challenge to improve birth outcomes by reducing infant mortality in the state.

c. Plan for the Coming Year

• A collaborative resource directory entitled A Connection for Families and Agencies: Resources for ND Families with Young Children Ages Birth ~ 8 will be periodically reviewed and continue to be made available on the ND Department of Health's web site. ND hospitals will be included in the directory, along with the various Neonatal Intensive Care Unit levels.
• State Title V staff will continue to support and collaborate with the Birth Review Program through Children's Special Health Services and the ND Department of Human Services. This program fosters inter and interagency partnerships to identify, inform and refer at risk newborn children to appropriate services.
• State Title V staff will continue partnership with the March of Dimes to improve infant health

outcomes.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	87	87.5	88	88.5	84.5
Annual Indicator	82.3	82.8	84.1	83.7	83.7
Numerator	7250	7393	7550	7603	7603
Denominator	8807	8931	8974	9088	9088
Data Source		See note field.	See note field.	See note field.	See note field.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	85	85.5	86	86.5	87

Notes - 2011
2011-Final 2010 data was used as provisional data for 2011. The source for this data is the North Dakota Department of Health -- Division of Vital Statistics.

Notes - 2010
2010-The source for this data is the North Dakota Department of Health -- Division of Vital Statistics.

Notes - 2009
2009- The source for this data is the North Dakota Department of Health - Division of Vital Statistics.

a. Last Year's Accomplishments
According to ND Vital Records data, the percent of infants born to pregnant women receiving prenatal care beginning in the first trimester has been fairly consistent between CY 2000 (85.0%) and CY 2010 (83.7%). The highest percent since CY 2000 was recorded during CY 2003 (86.5%) and the lowest was CY 2008 (82.3%).

Program accomplishments within the 2011 federal fiscal year include:
• Six local ND Optimal Pregnancy Outcome Programs (OPOP) were supported by a portion of Title V funds. The program provided educational materials to their clients in order to ensure the delivery of the healthiest baby possible, discussed hazards and their effect on pregnancy and fetus/baby beginning with the client's initial prenatal visit and referred to the appropriate programs as necessary.
• Local OPOP and Women, Infants and Children (WIC) staff discussed healthy practices during pregnancy and the importance of prenatal care, provided educational materials and distributed prenatal vitamins with folic acid and/or iron to their clients.
• The State OPOP director provided state and local OPOP contact information on the ND

Department of Health's website.
• Title V funding was continued for the Spirit Lake program at Fort Totten to provide prenatal care, infant care and immunizations.
• Title V staff participated in the March of Dimes committees which include activities relating to prematurity and grant review to provide for local activities/funding.
• State WIC purchased March of Dimes (MOD) materials for use in all clinics and two local WIC agencies received MOD grants for local activities.
• The Family Planning Program performed pregnancy testing and counseling including referral of those with a positive pregnancy test within 15 days to prenatal care and OPOP services. The Family Planning Program counseled and referred 403 clients in CY 2011 that had positive pregnancy tests as appropriate.
• The Birth Review mailings and the Parenting the First Year magazine continued to address the importance of early and adequate prenatal care. Parenting the First Year magazine can be viewed at:
http://www.ndhealth.gov/familyhealth/Publications/ParentingNewsletter/Parenting_Birthto12Months.pdf.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Six local ND Optimal Pregnancy Outcome Programs (OPOP) were supported by a portion of Title V funds.	X			
2. Local OPOP and Women, Infants and Children (WIC) staff discussed healthy practices during pregnancy and the importance of prenatal care, provided educational materials and distributed prenatal vitamins with folic acid and/or iron to their clients.		X		
3. The State OPOP director provided state and local OPOP contact information on the ND Department of Health's website.				X
4. Title V funding was continued for the Spirit Lake program at Fort Totten to provide prenatal care, infant care and immunizations.	X			
5. Title V staff participated in the March of Dimes committees which include activities relating to prematurity and grant review to provide for local activities/funding.				X
6. State WIC purchased March of Dimes (MOD) materials for use in all clinics and two local WIC agencies received MOD grants for local activities.		X		
7. The Family Planning Program performed pregnancy testing and counseling including referral of those with a positive pregnancy test within 15 days to prenatal care and OPOP services.	X			
8. The Birth Review mailings and the Parenting the First Year magazine continued to address the importance of early and adequate prenatal care.		X		
9.				
10.				

b. Current Activities
• Continue to support the Optimal Pregnancy Outcome Programs (OPOP) through utilization of a portion of Maternal and Child Health (MCH) funding.
• Local Women, Infants and Children (WIC) and OPOP staff provide information and education on the importance of healthy pregnancy practices and distribute prenatal vitamins with folic acid

and/or iron to clients.

c. Plan for the Coming Year

• Continue to support local Maternal and Child Health (MCH) grantees to utilize a portion of their Title V funding for the Optimal Pregnancy Outcome Program (OPOP); there are currently five OPOP sites throughout the state. One site has put services on hold due to no-show rates. The state will be providing technical assistance.
• Local OPOP and Women, Infants and Children (WIC) staff will discuss healthy practices during pregnancy and the importance of prenatal care, provide educational materials and distribute prenatal vitamins with folic acid and/or iron to their clients.
• The State OPOP Director will provide state and local OPOP contact information on the ND Department of Health's website.
• MCH will continue to provide funding for the Spirit Lake Sioux program at Fort Totten to provide prenatal care, infant care and immunizations.
• The Family Planning Program delegate agency staff will counsel and refer clients with positive pregnancy tests for pregnancy confirmation within 15 days to prenatal care and OPOP services, as appropriate.
• Title V staff will continue utilizing the Parenting The First Year Magazine and the Birth Review Program to inform women of the importance of early and adequate prenatal care.
• Title V staff will increase collaboration with the March of Dimes on healthy infant initiatives.

D. State Performance Measures

State Performance Measure 1: *The degree to which families and American Indians participate in Title V program and policy activities.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective			2.4	2.4	3
Annual Indicator			2	2	2
Numerator			2	2	2
Denominator			5	5	5
Data Source			see note	See note	See note
Is the Data Provisional or Final?					Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	3	3	4	4	4

Notes - 2011

2011-Final 2010 data was used as provisional data for 2011. The source for this data is from the North Dakota Department of Health--Division of Children's Special Health Services, Division of Family Health, Division of Injury Prevention and Control, and Division of Nutrition and Physical Activity. This measure is based on an annual assessment by each of the Title V funded programs in the North Dakota Department of Health which is used to assess efforts to form and strengthen partnerships with families and American Indians. An assessment tool was developed that measures both collaboration efforts of Title V funded programs as well as representation and participation of families and American Indians on committees, task forces and coalitions to achieve health equality in the maternal and child population. It is based on a qualitative assessment of Title V funded programs and measures partnership involvement and collaboration in 6 key areas for both families and American Indians. The assessment tool utilizes a 5 point scale for each key area. The measure is an average of the scores from each of the Title V funded

programs. The annual indicator is expressed as a whole number. Note: In 2010, the numerator had an average score of 2.43 and is rounded to 2 as a whole number.

Notes - 2010
2010-The source for this data is from the North Dakota Department of Health--Division of Children's Special Health Services, Division of Family Health, Division of Injury Prevention and Control, and Division of Nutrition and Physical Activity. This measure is based on an annual assessment by each of the Title V funded programs in the North Dakota Department of Health which is used to assess efforts to form and strengthen partnerships with families and American Indians. An assessment tool was developed that measures both collaboration efforts of Title V funded programs as well as representation and participation of families and American Indians on committees, task forces and coalitions to achieve health equality in the maternal and child population. It is based on a qualitative assessment of Title V funded programs and measures partnership involvement and collaboration in 6 key areas for both families and American Indians. The assessment tool utilizes a 5 point scale for each key area. The measure is an average of the scores from each of the Title V funded programs. The annual indicator is expressed as a whole number. Note: In 2010, the numerator had an average score of 2.43 and is rounded to 2 as a whole number.

Notes - 2009
2009- The source for this data is from the North Dakota Department of Health--Division of Children's Special Health Services, Division of Family Health, Division of Injury Prevention and Control, and Division of Nutrition and Physical Activity. This measure is based on an annual assessment by each of the Title V funded programs in the North Dakota Department of Health which is used to assess efforts to form and strengthen partnerships with families and American Indians. An assessment tool was developed that measures both collaboration efforts of Title V funded programs as well as representation and participation of families and American Indians on committees, task forces and coalitions to achieve health equality in the maternal and child population. It is based on a qualitative assessment of Title V funded programs and measures partnership involvement and collaboration in 6 key areas for both families and American Indians. The assessment tool utilizes a 5 point scale for each key area. The measure is an average of the scores from each of the Title V funded programs. The data is expressed as a number.
Note: In 2010 the numerator had an average score of 2.43 and is rounded to 2 as a whole number.

a. Last Year's Accomplishments
North Dakota Department of Health's (DoH) Maternal and Child Health (MCH) programs recognize that a partner-based approach in program planning is key to the improvement of MCH outcomes and the elimination of health disparities. An effective collaborative approach needs to engage a broad array of stakeholders, community partners, consumers and underrepresented populations.

From 2000 to 2010, ND's overall American Indian population grew 17 percent, from 31,329 to 36,591 people. In 2009, poverty rates for American Indian reservations ranged from 28 to 45.3 percent, and were much higher than the overall state rate of 12.3 percent. The Centers for Disease Control and Prevention explains that "social determinants of health like poverty, unequal access to health care, lack of education, stigma and racism are linked to health disparities."

In order to address health disparities through strengthened partnerships, MCH program administrators examined the degree of participation of families and American Indians with the following program and policy planning activities: collaboration around education activities, programmatic services, advocacy and public policy, data and community mobilization. Representation on Title V-related committees, task forces, coalitions, etc. was also included.

Findings from the FFY 2010 survey of MCH program involvement of American Indians and family members identified that, in general, programs reported to be either planning participation, or to

have some participation from American Indian members as well as Family Members.

Program accomplishments within the 2011 federal fiscal year include:
• Development of Title V/MCH State Performance Measure Fact Sheets. The fact for this priority/performance measure can be viewed at:
http://www.ndhealth.gov/familyhealth/FactSheets/SPM1Partnerships.pdf.
• The Division of Children's Special Health Services (CSHS) provided training to county social service staff. CSHS provided funding to Family Voices of ND (FVND) which conducted a variety of information and training activities, including the Parent Leadership Institute. Training on health benefits counseling was organized by FamNet. The Suicide Prevention Program and Coalition discussed forming an LGBTQ task force between the American Foundation for Suicide Prevention and the ND Department of Public Instruction focusing on bullying and suicide prevention.
• CSHS collaborated on Parent Navigator meetings and family training opportunities to develop partnerships that supported leadership development and mobilization of families at the grass roots level.
• The CSHS Family Advisory Council has two American Indian members. CSHS staff look at a variety of socio-determinant factors including diversity, urban/rural status, socio-economic status, ethnicity and gender when recruiting new members. The Injury Prevention and Control Conference Planning Committee has an Indian Affairs representative. There is representation on the State Intimate Partner and Sexual Violence Prevention Team from two different tribes and the first Nation's Women's Alliances. Family members were part of the final review group for Parenting the First Year magazine. Tribal representatives were invited to participate in the suicide prevention task force and representation is also present in the Suicide Prevention Coalition. The Suicide Prevention Planning Committee has been seeking "suicide survivors" for tribal member and family representation on the planning committee. The executive director of the First Nations Women's Alliance (state American Indian coalition) is a member of the STOP Violence Against Women Advisory Committee to review grant applications and assist with the three-year state plan for the STOP Violence Against Women grant. The Healthy ND Breastfeeding Committee is made up of representatives from a number of local breastfeeding coalitions; American Indians and families/new mothers are invited, but limited numbers participate.
• The DoH Cribs for Kids program staff met with several tribes/tribal leaders to discuss implementation of the program on their reservation. Three new Cribs for Kids Programs have been implemented in tribal entities including United Tribes Technical College, Spirit Lake Tribe American Indian MCH Program, and Turtle Mountain Chippewa through the Quentin Burdick Health Care Facility.
• CSHS and their partners accommodated individuals with disabilities in a variety of ways (e.g., wheelchair accessibility, etc.).
An attachment is included in this section. IVD_SPM1_Last Year's Accomplishments

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Development of Title V/MCH State Performance Measure Fact Sheets. The fact for this priority/performance measure can be viewed at: http://www.ndhealth.gov/familyhealth/FactSheets/SPM1Partnerships.pdf.				X
2. CSHS provided funding to Family Voices of ND (FVND) which conducted a variety of information and training activities, including the Parent Leadership Institute.				X
3. CSHS collaborated on Parent Navigator meetings and family training opportunities to develop partnerships that supported leadership development and mobilization of families at the grass roots level.				X

4. The CSHS Family Advisory Council has two American Indian members. CSHS staff look at a variety of socio-determinant factors including diversity, urban/rural status, socio-economic status, ethnicity, and gender when recruiting new members.				X
5. The DoH Cribs for Kids program staff met with several tribes/tribal leaders to discuss implementation of the program on their reservation. Three new Cribs for Kids Programs have been implemented in tribal entities.				X
6. CSHS and their partners accommodated individuals with disabilities in a variety of ways (e.g., wheelchair accessibility, etc.).		X		
7.				
8.				
9.				
10.				

b. Current Activities

• Title V staff participated in and distributed information to families on Sudden Infant Death Syndrome (SIDS), tobacco prevention and awareness, and health and academics at Spirit Lake Tribe Nation in Fort Totten.
• The Cribs for Kids program expanded to Fort Yates Early Childhood Program and to Elbowoods Memorial Health Care Center in New Town.
• The State Suicide Prevention Program utilized two American Indian Applied Suicide Intervention Skills Training (ASIST) trainers to conduct trainings at Tribal college campuses across the state in conjunction with Indian Affairs Commission and the Office for Elimination of Health Disparities.
• The State Suicide Prevention Program issued several grants to local tribal organizations to further suicide prevention efforts.
• Title V staff attended the Tribal Health Directors meeting and provided information on maternal and child health (MCH) programs with the goal to increase awareness and partnerships on MCH issues.
• Title V staff are partnering with Family Voices of ND to plan the October 18-19, 2012 ND Summit on Causal Leadership -- Leadership With Purpose.

c. Plan for the Coming Year

• In partnership with Family Voices of ND, Title V programs will sponsor and support the North Dakota Summit on Causal Leadership -- Leadership with a Purpose. Featured will be national expert and speaker Eileen Forlenza. The October 2012 conference will bring together key stakeholders to discuss a growing paradigm shift in partnering with families.
• Title V staff will participate in facilitated discussions between the Department of Health, Indian Affairs Commission and North Dakota State University's Master of Public Health program to develop strategies for increased efficiency and collaboration with tribal entities.
• In partnership with the Office for the Elimination of Health Disparities, Title V staff will begin on-going dialogue with tribal health leaders to identify areas of mutual concern and to strategize initiatives to improve health outcomes.

State Performance Measure 2: *The percent of Medicaid enrollees receiving Early Periodic Screening, Diagnosis and Treatment (EPSDT) screening services.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective				65.4	67

Annual Indicator		69.6	65.4	59.3	59.3
Numerator		31282	32885	32364	32364
Denominator		44969	50307	54535	54535
Data Source		See note field.	See note field.	See note field.	See note field.
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	68	69	70	71	72

Notes - 2011
2011-Final 2010 data was used as provisional data for 2011. The source for this data is from the North Dakota Department of Human Services -- Medical Services Division Health Tracks program. (CMS 416 annual EPSDT Participation Report). The numerator is the total screens received and the denominator is the expected number of Health Tracks (formerly EPSDT) screenings.

Notes - 2010
2010- The source for this data is from the North Dakota Department of Human Services -- Medical Services Division Health Tracks program. (CMS 416 annual EPSDT Participation Report). The numerator is the total screens received and the denominator is the expected number of EPSDT screenings.

Notes - 2009
2009-The source for this data is from the North Dakota Department of Human Services -- Medical Services Division Health Tracks program. (HCFA 416 annual EPSDT Participation Report). The numerator is the total screens received and the denominator is the expected number of EPSDT screenings.

a. Last Year's Accomplishments
Title V staff have developed strong working relationships with other state programs to strengthen age-appropriate screening, assessment and treatment for the MCH population. A strong working relationship exists between Children's Special Health Services (CSHS) and Medicaid staff. Examples include participation in a Pediatric Task Force; the Medicaid claims policy work group and ad hoc meetings to discuss coverage issues. CSHS continues to use the Medicaid Management Information System to pay claims. The State Systems Development Initiative Coordinator accesses Medicaid claims data for ND's passive Birth Defects Surveillance System. Title V staff are planning to provide Bright Futures toolkits and training to public health, Head Start and Health Tracks (formerly EPSDT) staff.

According to the ND Department of Human Services -- Medical Services Division Health Tracks program, 59.3 percent of Medicaid enrollees received Health Tracks screening services. The percent of Medicaid enrollees receiving this service continues to decline. In 2009, 65.4 percent of enrollees received Health Tracks screening services while 69.6 percent of enrollees received Health Tracks screening services in 2008.

Title V programs have placed priority on establishing and supporting a system of age appropriate screening, assessment, and treatment.

Program accomplishments within the 2011 federal fiscal year include:
• Development of Title V/MCH State Performance Measure Fact Sheets. The fact for this priority/performance measure can be viewed at:
http://www.ndhealth.gov/familyhealth/FactSheets/SPM2Screening.pdf.
• WIC staff asked about depression when certifying postpartum participants and referred, if appropriate.
• Title V staff monitored the number of children that received a screening through a variety of programs (e.g., Health Tracks (formerly EPSDT), Newborn Hearing, Oral Health, Newborn

Screening, etc.)
• Funding for the Maternal, Infant and Early Childhood Home Visiting Program was removed from the Department of Health's (DoH) budget during the 2011 legislative session, but Title V staff continued to work with Prevent Child Abuse North Dakota to promote additional home visiting opportunities.
• Title V staff started planning efforts with Medicaid's Health Tracks program to provide education on the use of Bright Futures as the framework for well-child care from birth to age 21 as well as other areas of interest to the MCH population. This training is scheduled to occur in the fall of 2012.
• The ND Family Planning program implemented a male services campaign. The data indicated that the number of male clients increased by five percent statewide. Family Planning clinics offer rapid and confirmatory HIV testing free-of-charge along with the other services that the clinics provide.
• The State School Nurse Consultant provided consultation and technical assistance to schools, nurses and public health in the areas of screening and other health related issues affecting students.
• The State Oral Health Program prepared the methodology and received Institutional Review Board approval in preparation for implementation of the Basic Screening Survey for Older Adults, an oral health screening study for long-term care facility residents in spring/summer 2012. Results of the survey will be used to guide oral health program prioritization and assist with the implementation of an oral health program to provide dental education and care to older adults throughout the state. The survey will measure tooth decay, gum inflammation, the presence of any oral lesions, and if the patients are wearing partials or dentures.
• The Cribs for Kids Program provided cribs for infants that were screened and identified with unsafe sleeping environments.
• The new child passenger safety (CPS) best practices from the American Academy of Pediatrics were distributed statewide to physicians and other organizations working with caregivers of young children. CPS materials were also created and distributed statewide for public information and education.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Development of Title V/MCH State Performance Measure Fact Sheets. The fact for this priority/performance measure can be viewed at: http://www.ndhealth.gov/familyhealth/FactSheets/SPM2Screening.pdf.				X
2. WIC staff asked about depression when certifying postpartum participants and referred, if appropriate.		X		
3. Title V staff monitored the number of children that received a screening through a variety of programs (e.g., Health Tracks (formerly EPSDT), Newborn Hearing, Oral Health, Newborn Screening, etc.).				X
4. Title V staff continued to work with Prevent Child Abuse North Dakota to promote additional home visiting opportunities.				X
5. Title V staff started planning efforts with Medicaid's Health Tracks program to provide education on the use of Bright Futures as the framework for well-child care from birth to age 21 as well as other areas of interest to the MCH population.				X
6. The ND Family Planning program implemented a male services campaign. The data indicated that the number of male clients increased by five percent state-wide.		X		
7. The State School Nurse Consultant provided consultation and				X

technical assistance to schools, nurses and public health in the areas of screening and other health related issues affecting students.				
8. The State Oral Health Program prepared the methodology and received Institutional Review Board approval in preparation for implementation of the Basic Screening Survey for Older Adults.				X
9. The Cribs for Kids Program provided cribs for infants that were screened and identified with unsafe sleeping environments.		X		
10. The new child passenger safety (CPS) best practices from the American Academy of Pediatrics were distributed statewide to physicians and other organizations working with caregivers of young children.		X		

b. Current Activities

• Direct service programs are incorporating postpartum depression screening and referral into their assessments, as appropriate (e.g., Family Planning, Optimal Pregnancy Outcome Program, WIC, etc.).
• The Family Planning Program is implementing the male services project to increase HIV and STD screening, diagnosis and treatment.
• Title V staff are collaborating with the Department of Human Services and the ND American Academy of Pediatrics to plan a fall/winter 2012 training on the use of Bright Futures as the framework for well-child care.
• Technical assistance is being provided to school nurses for school screenings (e.g., vision, hearing, scoliosis).
• The State Oral Health Program is conducting the Centers for Disease Control and Prevention and Association of State and Territorial Dental Directors Basic Screening Survey for Older Adults.
• The State Injury Prevention Program is providing materials for individuals to self-screen for injury prevention opportunities (e.g. child passenger safety, poison prevention, bike helmets, home safety).
• Children's Special Health Services provides diagnostic and treatment services for eligible children with special health care needs.

c. Plan for the Coming Year

• Strengthen the relationship with the Department of Human Services, Division of Medical Services (e.g., Medicaid and CHIP programs) to better achieve health outcomes for the MCH population.
• Encourage best practices through dissemination and training of Bright Futures Health Supervision Guidelines.
• Promote use of the Health Tracks (formerly EPSDT) Program to increase access to screening, diagnosis and treatment services for the MCH population ages birth to 21.

State Performance Measure 3: *The percent of children age 0 through 17 receiving health care that meets the American Academy of Pediatrics (AAP) definition of medical home.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective				36	64.5
Annual Indicator		64.0	64.0	64.0	64.0
Numerator		88102	88102	88102	88102
Denominator		137754	137754	137754	137754

Data Source		See note field.	See note field.	See note field.	See note field.
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	65	65.5	66	66.5	67

Notes - 2011
2011-Final 2010 data was used as provisional data for 2011. The source of this data is the 2007 National Survey of Children's Health (NSCH).The numerator is the weighted estimate of North Dakota children 0 through 17 who meet the criteria for having a medical home. The denominator is the weighted estimate of North Dakota children ages 0 through 17 years.

Notes - 2010
2010- The source of this data is the 2007 National Survey of Children's Health (NSCH).The numerator is the weighted estimate of North Dakota children 0 through 17 who meet the criteria for having a medical home. The denominator is the weighted estimate of North Dakota children ages 0 through 17 years.

Notes - 2009
2009-The source of this data is the 2007 National Survey of Children's Health (NSCH). The numerator is the weighted estimate of North Dakota children 0 through 17 who meet the criteria for having a medical home. The denominator is the weighted estimate of North Dakota children ages 0 through 17 years.

a. Last Year's Accomplishments
According to the 2007 National Survey of Children's Health (NSCH), nationally 57.5 percent of children age 0 through 17 received health care that met the American Academy of Pediatrics definition of medical home. In ND, 64.0 percent of children received such care. Although the state ranked significantly higher than the nation overall in this measure, apparent disparities exist for various groups.

According to the 2009/2010 National Survey of Children with Special Health Care Needs (NS-CSHCN), the percentage of CSHCN in ND who received coordinated, ongoing, comprehensive care within a Medical Home was 47.8 percent, which is slightly higher than the national percentage of 43.0 percent. The state and nation overall have seen a decrease in this core outcome since the 2005/2006 NS-CSHCN, where results were 51.2 percent and 47.1 percent respectively. In 2001, ND was at 54.7 percent; however, data for this indicator is not considered comparable across survey years.

Title V staff promote medical homes for CSHCN's and their families. Children's Special Health Services (CSHS) monitored the medical home status of children receiving services through the division's programs. State CSHCN program staff partnered with the Integrated Services Grant team by attending learning collaboratives, promoting development of quality medical home practices, and participating in strategic planning that addressed sustainability of an integrated service system for CYSHCN's in ND. Funding was provided by the Early Childhood Comprehensive System (ECCS) grant to support delivery of care coordination services in medical home pilot practices. Title V activities also included support for development of Dental Homes within the state. Healthy ND embraced a new coordinating role for a broad coalition that was established to address patient-centered medical homes in ND.

Results from the 2007 National Survey of Children's Health indicate that over one-fifth (22.8 %) of ND children were reported to have not seen a dentist for preventive care within the past 12 months, compared to the nation (21.6 %). ND children without special health care needs were less likely to have had a preventive dental visit within the past year (24.3 %) than children having special health care needs (16. 3 %).

Program accomplishments within the 2011 federal fiscal year include:
• Development of Title V/MCH State Performance Measure Fact Sheets. The fact for this priority/performance measure can be viewed at: http://www.ndhealth.gov/familyhealth/FactSheets/SPM3MedicalHome.pdf.
• Title V staff collaborated with the ND Center for Persons with Disabilities on modifications to the existing care coordination curriculum. CSHS also provided care coordination funding for Medical Home Pilot sites that were involved with the ND Integrated Services Project, which can be viewed at: http://www.ndcpd.org/ndis/index.shtml.
• Title V staff completed the following efforts: 1) a data exchange process was initiated to exempt children from the Medicaid Primary Care Provider program if the child was being served by CSHS, 2) the ECCS grant purchased Bright Futures Toolkits for a 2012 training to local public health, Head Start and medical home sites to assure quality health care, 3) ECCS members collaborated with stakeholders to review, recommend, and provide training on mental health screening tools for children, and 4) Title V program staff provided content for the ND Bridge to Benefits online screening tool which links families to public work support programs.
• The ND Oral Health Coalition (OHC) and State Oral Health Program staff collaborated with the Ronald McDonald House Charities on grant applications to support a Ronald McDonald House Charities Dental Care Mobile. A Health Resources and Services Administration (HRSA) grant was received by the DoH which provided supplies, equipment and staffing through a contract to the Dental Care Mobile for the years 2010 - 2013.
• The State Oral Health Program collaborated with Head Start on a special initiative to find dental homes for Head Start children. A special dental day was held on the Spirit Lake reservation on September 30, 2011. Many children on the reservation received preventative and restorative dental services. A video overview of the ND Spirit Lake Pediatric Dental Day can be viewed at: http://www.ndhealth.gov/oralhealth/DentalDay/SpiritLake.htm.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Development of Title V/MCH State Performance Measure Fact Sheets. The fact for this priority/performance measure can be viewed at: http://www.ndhealth.gov/familyhealth/FactSheets/SPM3MedicalHome.pdf.				X
2. Title V staff collaborated with the ND Center for Persons with Disabilities on modifications to the existing care coordination curriculum.				X
3. Title V program staff provided content for the ND Bridge to Benefits online screening tool which links families to public work support programs.		X		
4. The ND Oral Health Coalition (OHC) and State Oral Health Program staff collaborated with the Ronald McDonald House Charities on grant applications to support a Ronald McDonald Charities Dental Care Mobile.				X
5. The State Oral Health Program collaborated with Head Start on a special initiative to find dental homes for Head Start children. A special dental day was held on the Spirit Lake reservation on September 30, 2011.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

• The ND medical homes pilot sites are included as a target audience for the Bright Futures training scheduled for fall/winter 2012.
• The State Oral Health program is collaborating with the ND American Academy of Pediatrics to find dental homes for all the Head Start children in ND.

c. Plan for the Coming Year

• Monitor activities of the Patient Centered Medical Home Coalition and become engaged in work efforts as appropriate.
• Promote medical and dental home coordination, concept and practice for the MCH population.

State Performance Measure 4: *The percent of parents who reported that they usually or always got the specific information they needed from their child's doctor and other health care providers during the past 12 months.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective				86.3	87
Annual Indicator		86.3	86.3	86.3	86.3
Numerator		116692	116692	116692	116692
Denominator		135157	135157	135157	135157
Data Source		See note field.	See note field.	See note field.	See note field.
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	87.5	88	88.5	89	89

Notes - 2011

2011-Final 2010 data was used as provisional data for 2011. The source of this data is the 2007 National Survey of Children's Health (NSCH). The numerator is the weighted estimate of North Dakota parents reporting on the NSCH survey that they usually or always got specific information they needed from their child's doctors and other health care providers during the past 12 months. The denominator is the weighted estimate of total North Dakota parents responding to the NSCH survey question K5Q43.

Notes - 2010

2010-The source of this data is the 2007 National Survey of Children's Health (NSCH). The numerator is the weighted estimate of North Dakota parents reporting on the NSCH survey that they usually or always got specific information they needed from their child's doctors and other health care providers during the past 12 months. The denominator is the weighted estimate of total North Dakota parents responding to the NSCH survey question K5Q43.

Notes - 2009

2009-The source of this data is the 2007 National Survey of Children's Health (NSCH). The numerator is the weighted estimate of North Dakota parents reporting on the NSCH survey that they usually or always got specific information they needed from their child's doctors and other health care providers during the past 12 months. The denominator is the weighted estimate of total North Dakota parents responding to the NSCH survey question K5Q43.

a. Last Year's Accomplishments
According to the 2007 National Survey of Children's Health (NSCH), 86.3 percent of children had parents who usually or always received the specific information they needed from their child's health-care provider, which was higher than the national average of 84.8 percent. ND's goal is 89 percent.

In 2007, six percent of children ages birth through 17 had parents who indicated that they had no one to turn to for day-to-day emotional help with parenthood and raising children, according to the NSCH. This was better than the national average of 12 percent, but still reflects a segment of the population that has unmet emotional needs with parenting.

In accordance with the 2009-2010 National Survey of Children with Special Health Care Needs (NS-CSHCN), approximately 19.3 percent of families that had children with special health care needs reported their need for support services was going unmet. This is an increase from 2005-2006, when only 18.4 percent of families in ND reported unmet needs for support services. The national average is 19.5 percent.

Program accomplishments within the 2011 federal fiscal year include:
• Development of Title V/MCH State Performance Measure Fact Sheets. The fact for this priority/performance measure can be viewed at: http://www.ndhealth.gov/familyhealth/FactSheets/SPM4FamilySupportServices.pdf
• Results from a report entitled In Search of an Answer, Listening and Responding: North Dakota Survey of Children and Youth with Special Health Care Needs funded by the Early Childhood Comprehensive Systems (ECCS) and Family Voices of ND (FVND), which was based on a hypothetical scenario evaluating the experience of a parent to a child with special health care needs in the search for resources in ND, was analyzed and distributed by Children's Special Health Services (CSHS) staff and FVND through various educational opportunities and the FVND website. In Search of an Answer, Listening and Responding: North Dakota Survey of Agencies Serving Children and Youth with Special Health Care Needs can be viewed at: http://www.fvnd.org/yahoo_site_admin/assets/docs/FVND_Report_Final.33141636.pdf
• Funding for the Maternal, Infant and Early Childhood Home Visiting Program was removed from the DoH's budget during the 2011 legislative session, but Title V staff continued to work with Prevent Child Abuse North Dakota to promote additional home visiting opportunities.
• Title V staff have promoted the Healthy Steps/CHIP 877-KIDS-NOW and First Link 2-1-1 toll free lines by distributing informational materials (e.g., CSHS resource booklets, financial assistance packets, etc.) to partners and provided resource links on the CSHS webpage.
• Title V staff have collaborated with Human Services on updating the resource directory, A Connection for Families and Agencies: Resources for North Dakota Families with Young Children Ages Birth ~ 8. The 2008 version is available on the Family Health section of the DoH's web site.
• Title V staff partnered with various programs within and outside of the DoH to do combined newsletters, mailings, and/or order forms for program services. Examples include the Supplemental Security Income mailing, Birth Review Program, Parenting The First Year magazine and Focus on Oral Health newsletter.
• CSHS developed an annual Public Information Services plan that included operation of an Information Resource Center, in which outreach materials were sent to families via information requests. The CSHS outreach library contains reference books, brochures, packets, forms, journals, videos, etc. In FFY 2011, 92 percent of activities were completed in the Public Information Services plan.
• CSHS determined the effectiveness of information and referral efforts for children with special health care needs in collaboration with family partners. CSHS utilized a Health Information Satisfaction Survey to evaluate the quality of information families received. The survey, available through mailings and online, polled respondents on which method of obtaining health-related information was best for the family. CSHS provided funding to FVND who also evaluated health education and information center activities.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Development of Title V/MCH State Performance Measure Fact Sheets. The fact for this priority/performance measure can be viewed at: http://www.ndhealth.gov/familyhealth/FactSheets/SPM4FamilySupportServices.pdf				X
2. Results from a report entitled In Search of an Answer, Listening and Responding: North Dakota Survey of Children and Youth with Special Health Care Needs was analyzed and distributed by Children's Special Health Services (CSHS) staff.				X
3. Title V staff continued to work with Prevent Child Abuse North Dakota to promote additional home visiting opportunities.				X
4. Title V staff have promoted the Healthy Steps/CHIP 877-KIDS-NOW and First Link 2-1-1 toll free lines by distributing informational materials to partners and provided resource links on the CSHS webpage.		X		
5. Title V staff have collaborated with Human Services on updating the resource directory, A Connection for Families and Agencies: Resources for North Dakota Families with Young Children Ages Birth~8.		X		
6. Title V staff partnered with various programs within and outside of the DoH to do combined newsletters, mailings, and/or order forms for program services.		X		
7. CSHS developed an annual Public Information Services plan that included operation of an Information Resource Center, in which outreach materials were sent to families via information requests.		X		
8. CSHS determined the effectiveness of information and referral efforts for children with special health care needs in collaboration with family partners.				X
9.				
10.				

b. Current Activities

• In collaboration with family partners, Children's Special Health Services (CSHS) is determining the effectiveness of information and referral efforts for the children with special health care needs population.
• CSHS operates an Information Resource Center.
• Home Visiting Programs are being utilized to disseminate relevant maternal and child health (MCH) education and support service information.
• Title V partners with various programs to combine newsletters, mailings and/or order forms for program services (e.g., car safety seats/SIDS/tobacco, Parenting The First Year magazine, Birth Review, fact sheets, media campaigns).
• The State Suicide Prevention Program launched a new website that includes information on family support services and parent education.
• The State Suicide Prevention Program collaborated with Bismarck Burleigh Public Health to tape a segment for the Dakota Community Access channel on suicide prevention.

c. Plan for the Coming Year

• Collaboratively develop and distribute accurate educational materials for the MCH population to ensure consistency in messaging.

• Collaborate with the North Dakota Department of Human Services to update and disseminate the resource directory: A Connection for Families and Agencies: Resources for ND Families with Young Children Ages Birth ~ 8.
• Assist family-led organizations that provide information and support to the MCH population.
• Enhance the use of social media to provide public health education and build relationships with individuals and organizations that may not respond to traditional media.

State Performance Measure 5: *Increase the number of children ages 0 to 2 served by an evidenced-based home visiting program.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective				10.7	16
Annual Indicator		15.8	15.8	17.2	17.2
Numerator		279	279	310	310
Denominator		17618	17618	18047	18047
Data Source		See note field.	See note field.	See note field.	See note field.
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	17.4	17.5	17.6	17.7	17.8

Notes - 2011
2011-Final 2010 data was used as provisional data for 2011. The numerator is the total number of North Dakota children ages 0 to 2 served by an evidenced-based home visiting program. The sources for the numerator are Nurse Family Partnership in Fargo, the FACE program using parents as teachers model at the UTTC in Bismarck, Healthy Families of Grand Forks and Healthy Families of Bismarck. The denominator is from the U.S. Census Bureau, Population Division, 2010 Census. The rate is calculated per 1,000. Please note corrections for data reported in 2008. The numerator was reported as 279 with a rate of 15.8. The corrected data is 260 as the numerator with a rate of 14.8.

Notes - 2010
2010-The numerator is the total number of North Dakota children ages 0 to 2 served by an evidenced-based home visiting program. The sources for the numerator are Nurse Family Partnership in Fargo, the FACE program using parents as teachers model at the UTTC in Bismarck, Healthy Families of Grand Forks and Healthy Families of Bismarck. The denominator is from the U.S. Census Bureau, Population Division, 2010 Census. The rate is calculated per 1,000. Please note corrections for data reported in 2008. The numerator was reported as 279 with a rate of 15.8. The corrected data is 260 as the numerator with a rate of 14.8.

Notes - 2009
2009- Final 2008 data was used as provisional data for 2009. The numerator is the total number of North Dakota children ages 0 to 2 served by an evidenced-based home visiting program. The sources for the numerator are Nurse Family Partnership in Fargo, the FACE program using parents as teachers model at the UTTC in Bismarck, Healthy Families of Grand Forks and Healthy Families of Bismarck. The denominator is an annual estimate of the total North Dakota child population ages 0 to 2. The denominator is from the U.S. Census Bureau, Population Division, Vintage 2008 Population Estimates, Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: April 1, 2000 to July 1, 2009. The rate is calculated per 1,000.

a. Last Year's Accomplishments
Access to quality health care is essential to increase the likelihood of a healthy life of the MCH population. In addition to influencing overall physical, dental, mental and social health status, access to quality health care impacts prevention, detection and treatment of health conditions. Therefore, limited or no access to health care can be damaging to individual's' quality of life and aptitude to reach their full potential.

Home-visiting programs provide family-centered services to families that are expecting a newborn and/or have young children. Health-care professionals meet with families in their homes to focus on issues such as health care, nutrition education, positive parenting practices and access to services.

ND completed the first two phases for the Evidence Based Maternal, Infant and Childhood Home Visiting Program grant, however during the 2011 legislative session; the authority to implement this program was removed from the Department of Health's (DoH) budget. The DoH partnered with Prevent Child Abuse ND (PCAND) to continue collaboration related to evidence-based home visiting. The number of children per 1,000 served by an evidence-based home visiting program was 17.2 in 2010, an increase of 1.8 from 15.4 in 2009.

Program accomplishments within the 2011 federal fiscal year include:
• Development of Title V/MCH State Performance Measure Fact Sheets. The fact for this priority/performance measure can be viewed at:
http://www.ndhealth.gov/familyhealth/FactSheets/SPM5QualityHealthCare.pdf
• To increase access to care, many Children's Special Health Services (CSHS) grantees provided travel reimbursement for children with special health care needs and their families who attended clinics. A CSHS staff member participated on the ND State Council on Developmental Disabilities (NDSCDD). Transportation was included as an implementation activity in the 2012-2016 NDSCDD State Plan.
• The State Oral Health Program director continued to serve on the Ronald McDonald House Charities Dental Care Mobile Executive Committee. The Dental Care Mobile was ordered in June 2011 and is expected to arrive in January 2012. Direct services are expected to begin in February 2012 in Bismarck and expand to area communities within the first six months. The Dental Care Mobile will be serving children up to age 21 and will provide prevention and restorative services.
• The Oral Health Coalition supported dental loan repayment for safety net clinics during the 2011 legislative session. The one-time funding opportunity would have allowed $60,000 for three dentists to practice in a dental safety net clinic for a three-year period of time. Unfortunately, the bill was not passed.
• The State Oral Health Program was awarded a grant from the DentaQuest Foundation September 2011 to participate in its Oral Health 2014 Initiative. The multi-year initiative aims to eliminate disparities by supporting organizations that are building community partnerships. The Oral Health Program will work with a variety of partners to identify the reasons people lack access to oral health care and develop a plan for how to solve those issues.
• There are nine delegate Family Planning agencies statewide, along with 12 satellite clinics that provide counseling services to clients. The primary purpose of these agencies is to assist clients in making informed decisions regarding their reproductive health. The agencies provide education on the use of family planning options. Additional services include pregnancy diagnosis and counseling to clients in need.
• CSHS division staff conducted quality assurance activities on an ongoing basis. Examples of activities included programmatic monitoring of process and results measures including family satisfaction surveys. The division also required its grantees to address quality assurance strategies in funding proposals and annual reports that were submitted so that state staff could better evaluate services that have been funded. The ND Newborn Screening Program collaborated with Iowa staff on Quality Assurance conference calls which addressed laboratory procedures and follow-up processes. The ND Family Planning Program conducted internal medical audits and triennial site reviews with their delegate agencies.

• Title V staff continued to learn more about telemedicine opportunities that have the potential to increase access to care in ND.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Development of Title V/MCH State Performance Measure Fact Sheets. The fact for this priority/performance measure can be viewed at: http://www.ndhealth.gov/familyhealth/FactSheets/SPM5QualityHealthCare.pdf				X
2. Children's Special Health Services (CSHS) grantees provided travel reimbursement for children with special health care needs and their families who attended clinics.		X		
3. The State Oral Health Program director continued to serve on the Ronald McDonald House Charities Dental Care Mobile Executive Committee.				X
4. The Oral Health Coalition supported dental loan repayment for safety net clinics during the 2011 legislative session.	X			
5. The State Oral Health Program was awarded a grant from the DentaQuest Foundation September 2011 to participate in its Oral Health 2014 Initiative.				X
6. There are nine delegate Family Planning agencies state-wide, along with 12 satellite clinics, that provide counseling services to clients.	X			
7. CSHS division staff conducted quality assurance activities on an ongoing basis.				X
8. Title V staff continued to learn more about telemedicine opportunities that have the potential to increase access to care in ND.				X
9.				
10.				

b. Current Activities

• Title V programs facilitate quality assurance through activities such as the Tri-State Newborn Screening Quality Improvement conference call and Newborn Screening Quality Summit.
• MCH awards contracts to 27 local public health units, four non-profit agencies and three American Indian programs to support quality healthcare for the MCH population.
• A portion of Maternal and Child Health (MCH) funding is used to support the Nurse Family Partnership Home Visiting Program in Fargo.
• Title V staff participate on the Home Visiting Coalition, an initiative of Prevent Child Abuse ND.
• State Public Health Hygienists provide fluoride varnish and sealants through school-based programs.

c. Plan for the Coming Year

• Partner and support Prevent Child Abuse North Dakota to establish a network of evidence-based home visiting programs.
• Provide direct service safety-net programs (e.g., CSHS, family planning, oral health, etc.).
• Enhance partnership with the Community Health Care Association of the Dakotas (Community Health Centers).
• Participate in the Department of Health's process to obtain national public health accreditation aimed at advancing the quality and performance of Tribal, state, local, and territorial public health departments.

State Performance Measure 6: *Decrease the percent of students who reported feeling so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during the past 12 months.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective				22.9	22
Annual Indicator			22.9	22.9	22.9
Numerator			7094	7094	7094
Denominator			30990	30990	30990
Data Source			See note field.	See note field.	See note field.
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	21	20	19	18	17

Notes - 2011
2011-Final 2010 data was used as provisional data for 2011. The source for this data is selected weighted CDC data from the North Dakota 2009 Youth Risk Behavior Survey (YRBS). The YRBS includes data from high school (grades 9-12). The numerator is the weighted number of North Dakota high school students who answer "yes" to survey question #23 on the YRBS. The denominator is the total weighted number of high school students (grades 9-12) who completed the YRBS survey question #23.

Notes - 2010
2010- The source for this data is selected weighted CDC data from the North Dakota 2009 Youth Risk Behavior Survey (YRBS). The YRBS includes data from high school (grades 9-12). The numerator is the weighted number of North Dakota high school students who answer "yes" to survey question #23 on the YRBS. The denominator is the total weighted number of high school students (grades 9-12) who completed the YRBS survey question #23.

Notes - 2009
2009- The source for this data is selected weighted CDC data from the North Dakota 2009 Youth Risk Behavior Survey (YRBS). The YRBS includes data from high school (grades 9-12). The numerator is the weighted number of North Dakota high school students who answer "yes" to survey question #23 on the YRBS. The denominator is the total weighted number of high school students (grades 9-12) who completed the YRBS survey question #23.

a. Last Year's Accomplishments
Throughput life, mental health influences how individuals make decisions, manage stress and interact with others. Similar to physical health, mental health is important for optimal development at every stage of life. Early identification and linkage to services can often reduce the severity of mental health conditions.

According to the 2009 Youth Risk Behavior Survey (YRBS), 22.9 percent of ND high school students reported feeling so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during the past 12 months, as compared to 26.1 percent of U.S. high school students.

Program accomplishments within the 2011 federal fiscal year include:
• Development of Title V/MCH State Performance Measure Fact Sheets. The fact for this priority/performance measure can be viewed at:

http://www.ndhealth.gov/familyhealth/FactSheets/SPM6MentalSocialEmotional.pdf.
• In a continued effort to increase mental health screenings, psychologists participated in Children's Special Health Services (CSHS) sponsored cleft lip and palate, metabolic disorders, neuro-rehab, cerebral palsy and diabetes clinics.
• The State Suicide Prevention Program began to collaborate with the North Dakota Hospital Association (NDHA) to provide a model suicide assessment and standard operating procedures for all ND hospitals. The Suicide Prevention Program also began collaborating with Emergency Medical Services (EMS) to provide a standardized protocol for EMS workers to use when responding to someone who died by suicide, attempted suicide and their families.
• The State Suicide Prevention Program completed a variety of activities including the development of a newsletter on resiliency that was distributed in collaboration with the Coordinated School Health Back Pack Program; participation on the planning committee for the Out-of-the Darkness suicide prevention walk; the formation of a new suicide prevention task force to assist with strategic planning and partnership building; working with the Department of Public Instruction to provide anti-bullying grants to schools in ND; and suicide prevention messaging in the form of newsletters and press releases.
• Healthy ND Early Childhood Alliance members collaborated with stakeholders to review, recommend and provide training on mental health screening tools for children.
• Four of the Rape Prevention and Education (RPE) recipient agencies in ND have selected youth as their target populations and are working with their local prevention teams to provide bully prevention in their communities.
• CSHS explored potential coverage of mental health conditions under the CSHS Diagnostic and Treatment program, but was unable to expand due to funding constraints.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Development of Title V/MCH State Performance Measure Fact Sheets. The fact for this priority/performance measure can be viewed at: http://www.ndhealth.gov/familyhealth/FactSheets/SPM6MentalSocialEmotional.pdf.				X
2. In a continued effort to increase mental health screenings, psychologists participated in Children's Special Health Services (CSHS) sponsored cleft lip and palate, metabolic disorders, neuro-rehab, cerebral palsy and diabetes clinics.	X			
3. The State Suicide Prevention Program began to collaborate with the North Dakota Hospital Association (NDHA) to provide a model suicide assessment and standard operating procedures for all ND hospitals.				X
4. The State Suicide Prevention Program completed a variety of activities including the development of a newsletter on resiliency that was distributed in collaboration with the Coordinated School Health Back Pack Program.		X		
5. Healthy ND Early Childhood Alliance members collaborated with stakeholders to review, recommend, and provide training on mental health screening tools for children.				X
6. Four of the Rape Prevention and Education (RPE) recipient agencies in ND have selected youth as their target populations and are working with their local prevention teams to provide bully prevention in their communities.				X
7. CSHS explored potential coverage of mental health conditions under the CSHS Diagnostic and Treatment program, but was unable to expand due to funding constraints.				X

8.				
9.				
10.				

b. Current Activities

• The Sate Suicide Prevention Program started a pilot program in a primary care facility to conduct depression screening on adults and youth.
• The State Suicide Prevention Program issued a contract for the Applied Suicide Intervention Skills Training (ASIST) train the trainer program to be held in ND for up to 24 participants.
• The State Suicide Prevention Program developed a program for the National Suicide Prevention Lifeline to make outgoing calls and referrals to people experiencing suicidal thoughts.
• Information on depression is included in various publications (e.g. Health Guidelines for ND Schools, Parenting The First Year magazine, New Mother Fact sheets, A Connection Directory for Families and Agencies).
• The Children's Special Health Service's Diagnostic and Treatment program is covering depression services when it is related to the child's eligible condition.
• Direct service program such as Family Planning, Optimal Pregnancy Outcome Program and Women, Infants and Children (WIC) screen clients for depression.

c. Plan for the Coming Year

• Title V staff will collaborate with the Department of Health's state funded Suicide Prevention Program.
• Promote optimal mental health and social-emotional development by using consistent messaging disseminated through program educational materials.
• Strengthen on-going collaboration to improve mental health of the MCH population (e.g., Federation of Families, DHS Mental Health and Substance Abuse Division, Indian Affairs Commission, Children's Consultation Network, schools, etc.).

State Performance Measure 7: *The ratio of students per school nursing FTE.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					4300
Annual Indicator				4,357.2	4,357.2
Numerator				102830	102830
Denominator				23.6	23.6
Data Source				see note field.	see note field.
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	4250	4200	4150	4100	4050

Notes - 2011

2011-Final 2010 data was used as provisional data for 2011. The numerator reflects the number of students currently enrolled. The denominator is the current number of school nursing FTE's. The indicator is a ratio. The baseline of the revised survey indicates that North Dakota's school nurse to student ratio is 1:4,359. In addition, this survey indicated that we have approximately 23.6 FTE's for the entire state. Please note that most nurses are part-time positions and also may serve other programs. These numbers are inclusive of both the public and private sectors.

Notes - 2010

2010-The numerator reflects the number of students currently enrolled. The denominator is the current number of school nursing FTE's. The indicator is a ratio. The baseline of the revised survey indicates that North Dakota's school nurse to student ratio is 1:4,359. In addition, this survey indicated that we have approximately 23.6 FTE's for the entire state. Please note that most nurses are part-time positions and also may serve other programs. These numbers are inclusive of both the public and private sectors.

a. Last Year's Accomplishments

There is a growing awareness of the important link between health and education; children need to be healthy to learn and must learn to be healthy. Both early childhood and school-age nursing services support the continuum of the educational process by contributing positively to the health, health attitudes and behavior of today's child and consequently tomorrow's adult.

School nursing services are designed to be preventive in nature. They include education to encourage lifelong behaviors, first aid, screening, medication administration, injury prevention, nutrition education, physical activity promotion, emergency care, referrals and appropriate management of acute and chronic health conditions of students as well of staff. The ND School Nursing Services Survey is conducted every other year; participation in the survey is voluntary. In spring 2010, the survey indicated that there was approximately one nurse for every 4,357 students in ND, or about 23.6 full time equivalents (FTEs) for the entire state. The majority of school nurses work part time and the predominant model of school nursing delivery is through local public health units. The next survey collection is scheduled for Spring 2012.

Child care health consultants focus on health and wellness promotion in addition to injury and illness prevention. The consultant educates providers on topics such as safe sleep practices, common childhood illnesses/exclusion guidelines, children with special health care needs and community resources. As of September 2011, ND had the equivalent of only 2.5 child care health consultant FTEs for all licensed child-care providers.

Program accomplishments within the 2011 federal fiscal year include:
• Development of Title V/MCH State Performance Measure Fact Sheets. The fact for this priority/performance measure can be viewed at: http://www.ndhealth.gov/familyhealth/FactSheets/SPM7SchoolChildCareHealth.pdf.
• Results of the 2010 School Nursing Services Survey were distributed to school nurses, school health partners and other interested entities.
• The School Health Interagency/Community Workgroup developed a subcommittee focused on increasing access to school nursing services. The subcommittee was composed of members representing local public health, the ND Optometric Association, Early Childhood Comprehensive Systems Program, ND Nurses Association, ND Children's Caucus, ND School Nurse Organization, Nutrition & Physical Activity Program, Children's Defense Fund and the ND Parent Teacher Organization. A fact sheet was developed and disseminated that provided information on the status of school nursing in ND along with information about the role of the school nurse. This fact sheet provided education to policy makers and other entities. A bill was introduced during the 2011 Legislative Session for a 1 million appropriation of general funds to establish a school nurse program. Unfortunately, the bill did not pass.
• The State School Nurse Consultant collaborated with multiple entities focusing on children's health and provided technical assistance related to health issues in schools and child care.
• Children's Special Health Services collaborated with FamNet to foster increased partnerships that supported inclusive child care for children with special health care needs.
• Child care health consultants continued to participate on the Healthy ND Early Childhood Alliance.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Development of Title V/MCH State Performance Measure Fact Sheets. The fact for this priority/performance measure can be viewed at: http://www.ndhealth.gov/familyhealth/FactSheets/SPM7SchoolChildCareHealth.pdf.				X
2. Results of the 2010 School Nursing Services Survey were distributed to school nurses, school health partners and other interested entities.				X
3. The School Health Interagency/Community Workgroup developed a subcommittee focused on increasing access to school nursing services.				X
4. The State School Nurse Consultant collaborated with multiple entities focusing on children's health and provided technical assistance related to health issues in schools and child care.				X
5. Children's Special Health Services collaborated with FamNet to foster increased partnerships that supported inclusive child care for children with special health care needs.				X
6. Child care health consultants continued to participate on the Healthy ND Early Childhood Alliance.				X
7.				
8.				
9.				
10.				

b. Current Activities

• Title V staff collaborates with local public health, school nurses and child care health consultants to provide support and technical assistance for schools and child care.
• The State School Nurse Consultant is an active member of the National Association of School Nurses and the National Association of State School Nurse Consultants and will be attending the NASN conference and NASSNC Annual Meeting in June 2012.
• The State School Nurse Consultant serves on the leadership team for the ND Center for Nursing that is examining practice and policy issues that impact nursing and healthcare, such as school health.

c. Plan for the Coming Year

• Analyze and distribute the results of the 2012 School Nursing Services Survey.
• Provide state-level consultation and collaboration with various partners that support health services in schools and child-care settings.
• Develop materials to educate families, community members and decision makers about the importance and need for health services in schools and child-care settings.

State Performance Measure 8: *Reduce the percent of students who were bullied on school property during the past 12 months.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective				21.1	20.5
Annual Indicator			21.1	21.1	21.1
Numerator			6558	6558	6558
Denominator			31055	31055	31055
Data Source			See note	See note	See note

			field.	field.	field.
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	20	19.5	19	18.5	18

Notes - 2011
2011-Final 2010 data was used as provisional data for 2011. The source for this data is selected weighted CDC data from the North Dakota 2009 Youth Risk Behavior Survey (YRBS). The YRBS includes data from high school (grades 9-12). The numerator is the weighted number of students in grades 9 through 12 that responded "yes" to the YRBS question, indicating that they had been bullied on school property during the past 12 months. The denominator is the weighted number of students in grades 9 through 12 that responded to the question.

Notes - 2010
2010-The source for this data is selected weighted CDC data from the North Dakota 2009 Youth Risk Behavior Survey (YRBS). The YRBS includes data from high school (grades 9-12). The numerator is the weighted number of students in grades 9 through 12 that responded "yes" to the YRBS question, indicating that they had been bullied on school property during the past 12 months. The denominator is the weighted number of students in grades 9 through 12 that responded to the question.

Notes - 2009
2009-The source for this data is selected weighted CDC data from the North Dakota 2009 Youth Risk Behavior Survey (YRBS). The YRBS includes data from high school (grades 9-12). The numerator is the weighted number of students in grades 9 through 12 that responded "yes" to the YRBS question, indicating that they had been bullied on school property during the past 12 months. The denominator is the weighted number of students in grades 9 through 12 that responded to the question.

a. Last Year's Accomplishments
ND youth experience violence and bullying in school. Younger adolescents appear to be at greater risk. According to the 2009 Youth Risk Behavior Survey (YRBS), ND students in grades 7 and 8 were more likely to have been in at least one physical fight at school in the past year than students in grades 9 through 12 (13% compared to 7.4%), and more than twice as likely to have ever been bullied at school (49.9% compared to 21.1%).

In 2011, the ND legislature passed a bill regarding bullying prevention in public schools. The legislation requires school districts to implement a bullying policy before July 1, 2012.

Intimate partner violence affects individuals of all social, economic and racial/ethnic age groups. In 2012, there were at least 4,671 new victims who received services from the 21 crisis intervention centers across ND. At least 4,739 children were impacted by these incidents of intimate partner violence. According to the 2009 YRBS, 8.5 percent of students in grades 9 through 12 indicated they had been hit, slapped or physically hurt on purpose by their boyfriend or girlfriend in the past year.

Program accomplishments within the 2011 federal fiscal year include:
• Development of Title V/MCH State Performance Measure Fact Sheets. The fact for this priority/performance measure can be viewed at:
http://www.ndhealth.gov/familyhealth/FactSheets/SPM8ViolenceBullying.pdf.
• The YRBS and Behavioral Risk Factor Surveillance Survey data were distributed to each of the Sexual Violence Prevention Education (RPE) Domestic Violence/Rape Crisis agencies in ND as a means of evaluating each of their chosen prevention strategies.
• The Centers for Disease Control and Prevention awarded funding to the ND Department of Health (DoH) to manage the RPE cooperative agreement. The DoH awarded funding to nine local Domestic Violence/Rape Crisis agencies across the state. Each received training on bystander

education/intervention from different venues. During the 2010 ND Injury Prevention Conference, Alan Berkowitz provided a keynote and breakout session specifically related to Bystander Intervention. Four of the ND RPE recipient agencies selected youth as their target populations and are working with their local prevention teams to do bullying prevention.

• The ND Family Planning Program has guidelines related to sexual coercion and educational materials available at the nine agencies throughout the state. If there are any concerns that sexual coercion is occurring, the client is referred to other services provided in the community. In 2011, all Family Planning clinic training on sexual coercion, mandatory reporting and human trafficking.

• The State Suicide Prevention Program joined the bullying prevention circle, an online education forum facilitated by Children's Safety Network. The Suicide Prevention Program shared bullying information specifically related to the gay, lesbian, bisexual, transgendered population with the Suicide Prevention Task Force. The Suicide Prevention Program also discussed bullying prevention with tribal representatives at a Children's Sacred Bundle Gathering.

• Prevent Child Abuse ND, Students Against Destructive Decisions, domestic violence/rape crisis programs in Grand Forks, Stanley, and Minot, ND National Guard, Minot Air Force Base, ND Protection and Advocacy Project, First Nation's Women's Alliance, Prairie St. John's and United Tribes Technical College continued as collaborating members of the Intimate Partner and Sexual Violence Prevention Team.

• The Division of Injury Prevention and Control collaborated with several agencies to rewrite the ND Injury Prevention Plan that included primary prevention and intervention strategies related to bullying and intimate partner violence. The plan can be viewed at: http://www.ndhealth.gov/injury/Publications/IPC%20Plan%20Final%202010.pdf.

• In March 2011, Family Voices of ND held a topical call that discussed bullying and children with special health care needs. The April 2011 Pathfinder Conference included a presentation by Scott Burlingame titled The Era of Kids will be Kids is Over: Bullying and Kids with Disabilities in 2011.

• A member of the Coordinated School Health team attended the Youth Alliance meeting in May 2011. Programs shared updates on YRBS data and discussed legislative bills, including those related to bullying.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Development of Title V/MCH State Performance Measure Fact Sheets. The fact for this priority/performance measure can be viewed at: http://www.ndhealth.gov/familyhealth/FactSheets/SPM8ViolenceBullying.pdf.				X
2. The YRBS and Behavioral Risk Factor Surveillance Survey data were distributed to each of the Sexual Violence Prevention Education (RPE) Domestic Violence/Rape Crisis agencies in ND as a means of evaluating each of their chosen prevention strategies.				X
3. The Centers for Disease Control and Prevention awarded funding to the ND Department of Health (DoH) to manage the RPE cooperative agreement.				X
4. The ND Family Planning Program has guidelines related to sexual coercion and educational materials are available at the nine agencies throughout the state.		X		
5. The State Suicide Prevention Program joined the bullying prevention circle, an online education forum facilitated by Children's Safety Network.				X
6. Various entities continued as collaborating members of the Intimate Partner and Sexual Violence Prevention Team.				X

7. The Division of Injury Prevention and Control collaborated with several agencies to rewrite the ND Injury Prevention Plan that included primary prevention and intervention strategies related to bullying and intimate partner violence.				X
8. In March 2011, Family Voices of ND held a topical call that discussed bullying and children with special health care needs.				X
9. A member of the Coordinated School Health team attended the Youth Alliance meeting in May 2011. Programs shared updates on YRBS data and discussed legislative bills, including those related to bullying.				X
10.				

b. Current Activities

• The State Suicide Prevention Program director participates in Bismarck school's bullying prevention task force.
• The State Suicide Prevention Program issued a grant to the South East Education Cooperative to engage 10 schools using the Olweus bullying prevention program.
• The ND Council on Abused Women Services receives funding from Title V to support data collection and analysis.
• Title V staff are reviewing the results of the Youth Risk Behavior Survey (YRBS) which has specific questions related to bullying against youth and children with special health care needs.
• Local Family Planning staff addresses sexual coercion and domestic violence with all clients and provides referrals to social services, safe houses and counseling services.

c. Plan for the Coming Year

• Continue collaboration with various groups to address violence in the MCH population.
• Analyze and distribute the results of the Youth Risk Behavior Survey related to violence along with other risk behaviors.

State Performance Measure 9: *The rate of deaths to individuals ages 1 through 24 caused by intentional and unintentional injuries per 100,000 individuals.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective				59.9	29
Annual Indicator		28.7	30.0	32.9	32.9
Numerator		64	67	73	73
Denominator		223172	223647	221960	221960
Data Source		See note field.	See note field.	See note field.	See note field.
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	28	27	26	25	24

Notes - 2011

2011-Final 2010 data was used as provisional data for 2011. The source for the numerator is the North Dakota Department of Health, Division of Vital Statistics. The denominator is from the U.S. Census Bureau, Population Division, 2010 U.S. Census. The numerator is the total number of deaths to individuals ages 1 through 24 due to intentional and unintentional injuries within the calender year. The denominator is the estimated number of individuals age 1 through 24 for the specific calender year. The rate is calclulated per 100,000.

Notes - 2010
2010- The source for the numerator is the North Dakota Department of Health, Division of Vital Statistics. The denominator is from the U.S. Census Bureau, Population Division, 2010 U.S. Census. The numerator is the total number of deaths to individuals ages 1 through 24 due to intentional and unintentional injuries within the calender year. The denominator is the estimated number of individuals age 1 through 24 for the specific calender year. The rate is calclulated per 100,000.

Notes - 2009
2009-The source for the numerator is the North Dakota Department of Health, Division of Vital Statistics. The denominator is from the U.S. Census Bureau, Population Division, Vintage 2008 Population Estimates, Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: April 1, 2000 to July 1, 2009. The numerator is the total number of deaths to individuals ages 1 through 24 due to intentional and unintentional injuries within the calender year. The denominator is the estimated number of individuals age 1 through 24 for the specific calender year. The rate is calclulated per 100,000.

a. Last Year's Accomplishments
Deaths resulting from injuries with harmful intent are considered intentional (e.g., suicide) while those due to injuries done without harmful intent are considered unintentional (e.g., motor vehicle crashes).

The rate of deaths to individuals ages 1 through 24 due to intentional and unintentional injuries increased from 30 per 100,000 in 2009 to 32.9 per 100,000 in 2010. Over this time period, the population in this age range decreased from 223,647 in 2009 to 221,960 in 2010. An increase in deaths and decrease in population size may be the cause of the higher mortality rate.

From 2006 through 2010, the rate of death among children and youth ages 1 through 24 was 44 per 100,000 (492 deaths). Injury-related deaths were the leading causes of death (46.3% unintentional and 26% intentional). The injury death rate for individuals ages 1 through 24 was 31.8 per 100,000; the rate among American Indians was more than three times higher than whites (92.8 among American Indians compared to 26.4 among whites). Motor vehicle crash deaths were the leading cause of injury-related deaths among individuals ages 1 through 24. Suicide was the next most common cause of injury-related death for individuals ages 1 through 24, followed by unintentional poisoning, homicide and drowning.

Program accomplishments within the 2011 federal fiscal year include:
• Development of Title V/MCH State Performance Measure Fact Sheets. The fact for this priority/performance measure can be viewed at: http://www.ndhealth.gov/familyhealth/FactSheets/SPM9Injuries.pdf.
• The Child Passenger Safety (CPS) program received funding from the Department of Transportation. Funds were used for CPS public information and education, trainings, car seat checkup supplies and car seats. The program collaborated with Women, Infant and Children (WIC), public health, Head Start and Early Head Start, clinics, Safe Communities Coalitions, law enforcement, Safe Kids Coalitions and others that work with caregivers who have contact with children.
• The CPS program coordinates with the Division of Children's Special Health Services to distribute CPS best practices and special needs car seat information to families and program partners.
• The Division of Injury Prevention and Control (IPC) was represented on the core planning committee formed to implement Graduated Driver's License requirements for new teen drivers in ND. Through the efforts of the committee and others, the minor driver's license law was strengthened during the 2011 legislative session. A "No Texting" law for all ND drivers was also passed during the 2011 session.
• The Division of IPC collaborated with several agencies to rewrite the ND Injury Prevention Plan

that included primary prevention and intervention strategies. The plan can be viewed at: http://www.ndhealth.gov/injury/Publications/IPC%20Plan%20Final%202010.pdf.
• The October 2010 IPC Conference was held with approximately 150 people in attendance. The goal of the conference was to inform participants of best practices for unintentional and intentional injuries.
• The Division of IPC provided Bicycle Safety Activity Kits, poison prevention and information brochures, magnets and stickers with the Poison Helpline phone number and a DVD for children under the age of five. Two Poison Prevention 101 classes were held; a total of 75 people attended. A toolkit was provided to each attendee to conduct workshops on poison prevention in their areas. The Building Blocks to Safety newsletter, a publication promoting product safety, was completed quarterly and shared. The ND poison website was available for downloads of materials. The website can be viewed at: www.ndpoison.org.
• The Division of IPC partnered with the ND Council on Abused Women's Services/Coalition Against Sexual Assault to work on strategies for the primary prevention of sexual assault. Many of the local Domestic Violence/Rape Crisis agencies used an approach to anti-bullying as a means to prevent sexual violence.
• The ND Department of Health participated on the Child Fatality Review Panel. The panel made recommendations to the state for the prevention of teen motor vehicle and suicide deaths. The Child Fatality Review Panel 2007-2009 Annual Report can be viewed at: http://www.nd.gov/dhs/info/pubs/docs/cfs/child-fatality-report-2007-2009.pdf.
• The State Suicide Prevention Program developed a suicide prevention survey that was administered statewide.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Development of Title V/MCH State Performance Measure Fact Sheets. The fact for this priority/performance measure can be viewed at: http://www.ndhealth.gov/familyhealth/FactSheets/SPM9Injuries.pdf.				X
2. The Child Passenger Safety (CPS) program received funding from the Department of Transportation. Funds were used for CPS public information and education, trainings, car seat checkup supplies and car seats.		X		
3. The CPS program coordinates with the Division of Children's Special Health Services to distribute CPS best practices and special needs car seat information to families and program partners.		X		
4. The Division of Injury Prevention and Control (IPC) was represented on the core planning committee formed to implement Graduated Driver's License requirements for new teen drivers in ND.				X
5. The Division of IPC collaborated with several agencies to rewrite the ND Injury Prevention Plan that included primary prevention and intervention strategies.				X
6. The October 2010 IPC Conference was held with approximately 150 people in attendance. The goal of the conference was to inform participants of best practices for unintentional and intentional injuries.				X
7. The Division of IPC provided Bicycle Safety Activity Kits, poison prevention and information brochures, magnets and stickers with the Poison Helpline phone number and a DVD for children under the age of five.		X		

8. The Division of IPC partnered with the ND Council on Abused Women's Services/Coalition Against Sexual Assault to work on strategies for the primary prevention of sexual assault.				X
9. The ND Department of Health participated on the Child Fatality Review Panel. The panel made recommendations to the state for the prevention of teen motor vehicle and suicide deaths.				X
10. The State Suicide Prevention Program developed a suicide prevention survey that was administered statewide.				X

b. Current Activities

• The Coordinated School Health program collaborated with Injury Prevention and Control to promote bicycle safety by providing students a bike helmet through the Physical Activity Backpack Program targeted at fourth grade students.
• The State Injury Prevention and Control Program disseminated information regarding new legislation affecting teen drivers and parents to the local public health agencies.
• The Injury Prevention Coalition implemented prevention strategies from the State Plan with emphasis on motor vehicle crashes, suicide, falls, unintentional poisoning, ATV, drowning, farm injuries, and domestic/sexual violence.
• Two Poison Prevention 101 Train-the-Trainer sessions were conducted for participants from public health, Head Start, childcare, businesses, medical providers and the general public.
• Planning is underway for the October 2012 Injury Prevention and Control Conference.

c. Plan for the Coming Year

• Support the October 2012 North Dakota Conference on Injury Prevention and Control "Preventing and Responding to Injuries."
• Monitor legislation to reduce injury and death in the MCH population (e.g., graduated driver's license, etc.).
• Use consistent messaging throughout injury prevention and control education efforts, including the use of social media.
• Collaborate with partners and organizations that support efforts to strengthen injury prevention and awareness activities.

State Performance Measure 10: *The percent of healthy weight among adults ages 18 through 44.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective				39.6	37
Annual Indicator		35.6	36.8	40.2	40.2
Numerator		79706	84583	91202	91202
Denominator		223933	229739	227082	227082
Data Source		See note field.	See note field.	See note field.	See note field.
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	40.3	40.4	40.5	40.6	40.7

Notes - 2011

2011-Final 2010 data was used as provisional data for 2011. The data for perecent of healthy weight among adults from age 18 through 44 was collected from the 2010 Behavioral Risk Factor Surveillance Survey (BRFSS). Both the numerator and denominator are weighted estimates.The

numerator is the weighted number of respondents ages 18 through 44 with body mass index (BMI) greater or equal to 18.5 and < 25.0. The denominator is the weighted number of respondents ages 18 through 44 providing height and weight information in the BRFSS.

Notes - 2010
2010-The data for perecent of healthy weight among adults from age 18 through 44 was collected from the 2010 Behavioral Risk Factor Surveillance Survey (BRFSS). Both the numerator and denominator are weighted estimates.The numerator is the weighted number of respondents ages 18 through 44 with body mass index (BMI) greater or equal to 18.5 and < 25.0. The denominator is the weighted number of respondents ages 18 through 44 providing height and weight information in the BRFSS.

Notes - 2009
2009-The data for perecent of healthy weight among adults from age 18 through 44 was collected from the 2007 and 2008 Behavioral Risk Factor Surveillance Survey (BRFSS). Both the numerator and denominator are weighted estimates. The numerator is the weighted number of respondents ages 18 through 44 with body mass index (BMI) greater or equal to 18.5 and < 25.0. The denominator is the weighted number of respondents ages 18 through 44 providing height and weight information in the BRFSS.

a. Last Year's Accomplishments
A balanced diet and regular physical activity benefit the health of children and adults. Poor diet and physical inactivity contribute to many serious and costly health conditions including obesity, heart disease, diabetes, some cancers, unhealthy cholesterol and high blood pressure.

Overweight and obesity are occurring at younger ages. Among low-income North Dakota children ages 2 through 4 enrolled in WIC in 2010, nearly one in three was considered overweight (16.8%) or obese (14.1%). American Indian children were twice as likely to be obese as white children (22.1% compared to 11.2%).

While 65 percent of students in grade 7 met recommended levels of physical activity in 2009, only 41.7 percent of students in grade 12 did. In 2008, nearly all North Dakota schools required physical education for students in grade 7 (97.8%), but only 32.9 percent required it for students in grade 12. Among North Dakota high school students in grades 9 through 12, only 13.7 percent consumed enough (i.e., at least five) servings of fruits and vegetables per day in 2009.

The ND Behavioral Risk Factor Surveillance System data shows that in 2010, only 40 percent of adults reported a healthy BMI. The proportion of healthy-weight adults decreases with age. While 54.2 percent of ND adults ages 18 through 24 were at a healthy weight in 2010, the percentage decreased to 38.5 percent among adults ages 25 through 34 and to 32.1 percent among adults ages 35 through 44.

Program accomplishments within the 2011 federal fiscal year include:
• Development of Title V/MCH State Performance Measure Fact Sheets. The fact for this priority/performance measure can be viewed at: http://www.ndhealth.gov/familyhealth/FactSheets/SPM10HealthyWeight.pdf.
• The State Maternal and Child Health (MCH) Nutritionist promoted consistent messaging on healthy eating and physical activity by encouraging breastfeeding initiation, duration and exclusivity; limiting television viewing and screen time; reducing consumption of sugar sweetened beverages and high-energy-dense foods; increasing consumption of fruits and vegetables and low fat milk; and increasing physical activity and movement.
• The State MCH Nutritionist reviewed the third grade height, weight, milk and soda consumption data that was collected in collaboration with the Oral Health Basic Screening Survey. A fact sheet is being developed to highlight the data.
• The State MCH nutritionist served on the Physical Activity in Child Care Advisory Committee formed as part of the Communities Putting Prevention to Work grant funding. The advisory

committee is made up of members from child care resource and referral, early childhood programs, various Health and Human Service programs and child care providers. Activities of the committee included trainings for child care providers, putting together a best practices document for physical activity in child care, a "Move, Play, and Learn" CD on physical activity for child care providers and a media campaign with online, radio and TV ads promoting physical activity in child care settings.

• The Coordinated School Health program offered PIPEline and Spark physical education trainings that encouraged physical activity teaching strategies to 130 school staff participants during 2011.

• State Women, Infants and Children (WIC) and Healthy Communities (HC) staff participated in activities, trainings, and planning for Healthy ND Worksite Wellness initiatives including collaboration with the infant friendly worksite designation program in which businesses are able to voluntarily put a policy in place which meets set criteria to achieve an infant friendly breastfeeding support designation. In 2011, there were 26 businesses that achieved the ND Infant Friendly designation.

• The HC Nutritionist provided technical assistance to the Moving More/Eating Smarter (MMES) communities with grant activities.

• The Children's Special Health Services director participated on the ND Disability Health Project Advisory Council. The project's goal was to promote health and wellness of ND citizens with disabilities, and prevent or lessen the effects of secondary conditions associated with disabilities. The Disability Health Project is a collaborative effort between the ND Center for Persons with Disabilities at Minot State University, the Center for Rural Health at the University of ND and the ND Department of Health.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Development of Title V/MCH State Performance Measure Fact Sheets. The fact for this priority/performance measure can be viewed at: http://www.ndhealth.gov/familyhealth/FactSheets/SPM10HealthyWeight.pdf.				X
2. The State Maternal and Child Health (MCH) Nutritionist promoted consistent messaging on healthy eating and physical activity by encouraging breastfeeding initiation, duration and exclusivity; limiting television viewing and screen time; reducing		X		
3. The State MCH Nutritionist reviewed the third grade height, weight, milk and soda consumption data that was collected in collaboration with the Oral Health Basic Screening Survey. A fact sheet is being developed to highlight the data.				X
4. The State MCH nutritionist served on the Physical Activity in Child Care Advisory Committee formed as part of the Communities Putting Prevention to Work grant funding.				X
5. The Coordinated School Health program offered PIPEline and Spark physical education trainings that encouraged physical activity teaching strategies to 130 school staff participants during 2011.				X
6. State Women, Infants and Children (WIC) and Healthy Communities (HC) staff participated in activities, trainings, and planning for Healthy ND Worksite Wellness initiatives.				X
7. The HC Nutritionist provided technical assistance to the Moving More/Eating Smarter (MMES) communities with grant activities.				X
8. The Children’s Special Health Services director participated				X

on the ND Disability Health Project Advisory Council.				
9.				
10.				

b. Current Activities

• Maternal and Child Health (MCH) local public health nutritionists collaborate on healthy eating and physical activity events in their communities that reach the MCH population including those with special health care needs.
• The State MCH Nutritionist worked with the ND Cancer Coalition to develop materials focusing on healthy eating and physical activity around the holidays.
• Local Title V and Women, Infants and Children (WIC) staff educate prenatal clients in breastfeeding and promote it as the optimal method of feeding healthy infants.
• Local Family Planning and WIC staff collect BMI information on clients and provide education, counseling and/or referrals as appropriate.
• WIC staff provide tailored food packages and personalized nutrition education after a thorough nutrition assessment and make referrals to health care providers for additional services as needed.
• The Coordinated School Health (CSH) Program distributed the Physical Activity Backpack program targeted at fourth grade students to nine schools during the 2011-12 school year.
• The CSH Program facilitated five educator workshops based on the Coordinated Approach to Child Health (CATCH) and Program Improvement in Physical Education (PIPEline) curriculum to promote physical activity and nutrition to students.
• Optimal Pregnancy Outcome Program (OPOP) nutritionists educate prenatal clients on making healthy and informed decisions.

c. Plan for the Coming Year

• Title V staff will collaborate with and provide technical assistance to communities and organizations that support healthy eating and physical activity policies and initiatives.
• Promote healthy eating and physical activity by using consistent messaging disseminated through program educational materials including the use of social media (e.g., breastfeeding, etc.).
• Title V staff will participate in the Coordinated Chronic Disease Grant partnership.

E. Health Status Indicators

/2013/ ND's Title V program considers all Health Status Indicators (HSI) relevant to discuss.

The State Systems Development Initiative (SSDI) Coordinator collects the data for all of the HSIs. The SSDI initiative supports the Maternal and Child Health program in accessing relevant information for program monitoring/evaluation and policy development.

#01A. The percent of live births weighing less than 2,500 grams.

The percentage of live births weighing less than 2,500 grams has remained stable over the past 10 years varying from 6.2 to 6.8 percent. In 2010, 6.7 percentage of live births weighed less than 2,500 grams. Drawing conclusions on this data is difficult due to the small numbers.
Prematurity is the leading killer of America's newborns. Those who survive often have lifelong health problems, including cerebral palsy, intellectual disabilities, chronic lung disease, blindness and hearing loss. Half of all neurological disabilities in children are

related to premature birth. Prevention and wellness initiatives can help to reduce both the short- and long-term impacts of chronic conditions.
In an effort to improve birth outcomes, ND has signed the Association of State and Territorial Health Official's (ASTHO) 2012 President's Challenge. Activities aimed at improving birth outcomes include:

• In partnership with the Office for the Elimination of Health Disparities, Title V staff will begin ongoing dialogue with tribal health leaders to identify areas of mutual concern and to strategize initiatives to improve infant health outcomes.

• Partner with the March of Dimes and KAT Communications to incorporate The Coming of the Blessing -- A Pathway to a Healthy Pregnancy booklet into programs that work with maternal and child health populations.

• Collaborate with a variety of partners (i.e., third party payers) on messaging that utilizes the March of Dimes media campaigns that encourage pregnant women to wait until 39 completed weeks of gestation before elective delivery.

Additional program strategies in place to maintain and/or enhance this Indicator are the same as in HSCI #04.

#01B. The percent of live singleton births weighing less than 2,500 grams.

The percent of live singleton births weighing less than 2,500 grams has remained stable over the last five years from 4.4 to 4.9 percent. 2010 data reports 4.9 percent. Drawing conclusions on this data is difficult due to the small numbers.

Program strategies and policy and program relevant information is the same for this Indicator as in HSI #01A and HSCI #04.

#02A. The percent of live births weighing less than 1,500 grams.

The percent of live births weighing less than 1,500 grams has remained stable over the last five years from 1.1 percent to 1.3 percent. 2010 data reports 1.1 percent. Drawing conclusions on this data is difficult due to the small numbers.

Program strategies and policy and program relevant information is the same for this Indicator as in HSI #01A and HSCI #04.

#02B. The percent of live singleton births weighing less than 1,500 grams.

The percent of live singleton births weighing less than 1,500 grams has remained stable over the last five years from 0.8 percent to 0.9 percent. 2010 data reports 0.8 percent. Drawing conclusions on this data is difficult due to the small numbers.

Program strategies and policy and program relevant information is the same for this Indicator as in HSI #01A and HSCI #04.

#03A. The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.

The source for this data is the ND Department of Health (DoH), Division of Vital Records.

The death rate per 100,000 due to unintentional injury among children age 14 years and younger have varied over the past five years. In 2010, one third of the deaths were due to drowning. Drawing conclusions on this data is difficult due to the small numbers.

This Indicator is critical because unintentional injuries are the leading cause of death to all children ages 1 through 14 in ND. Program strategies in place to maintain and/or enhance this indicator include: ongoing public education regarding child passenger safety (CPS) best practices and the ND CPS law. CPS resources are distributed statewide for parents, caregivers, agencies and others who work with caregivers of young children. The ND Department of Health (DoH) facilitates over 40 statewide car seat distribution programs. CPS trainings are conducted for professionals, car seat checkups are offered to teach the public how to correctly use car seats; and CPS month activities promoted to children of elementary school ages and younger in February of each year.

Efforts for the prevention of unintentional injuries for MCH are varied and diversified. They include poison prevention which involves distribution of educational materials, magnets and phone stickers that have the Poison Helpline number on it; promotion of the annual Poison Prevention Week when the previous year's ND poison statistics were released; and, two Poison Look Alike Kits used throughout the state at health fairs and parent educational sessions. A partnership between the DoH and ND Safety Council hosted two Train-the-Trainer sessions for Poison Prevention 101 where attendees received information about Poison and a DVD that provided them with all of the information they would need to host their own training. Bike Safety month is promoted through a statewide news release and distribution of bike safety educational materials which includes a DVD "The Bike Safety Kit" for kindergarten through grade six children. The Home Safety Checklist continues to be a much sought after publication by multiple partners. News releases are issued throughout the year which include prevention messages about bike helmet use, unintentional poisoning, playground and traffic safety. Product safety recall effectiveness checks are completed throughout the state, and the publication of a quarterly newsletter is distributed to educate the public about product safety issues.

The ND Injury Prevention Coalition is a multi-disciplinary partnership with a mission to reduce unintentional and intentional injuries and deaths. Members of the Coalition include multiple state agencies such as Game and Fish, Emergency Medical Services and Department of Public Instruction; members of the Indian Health Services and Tribal Injury Prevention specialists, as well as non-profit organizations such as the ND Safety Council, American Automobile Association, two local Level 2 Trauma Center hospitals and other child safety advocates. The ND Injury Prevention Plan which was written in 2010 has emphasis on motor vehicle crashes, falls, ATVs, drowning, poisoning and domestic and sexual violence. The third Statewide Injury Prevention and Control Conference is scheduled for October 2012 and the planning is under way. This conference will feature topics pertinent to children such as traumatic brain injury; and traffic and pool safety.

Our desired outcome is to reduce unintentional injury deaths in ND for children 1 through 14 with a special focus on reducing deaths due to drowning. Prevention strategies to reduce these deaths are outlined in the 2010 ND Injury Prevention Plan and are implemented through partnerships with various state wide agencies and organizations. Policy and programming changes are also addressed in the State Plan. Data and activities relating to drowning can be found on pages 47-50 of the Injury Prevention plan: http://www.ndhealth.gov/injury/Publications/IPC%20Plan%20Final%202010.pdf. Additional funding is needed to increase programmatic activities and to promote additional efforts at the local level.

#03B. The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among children aged 14 years and younger.

The source for this data is the ND Department of Health (DoH), Division of Vital Records. The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among children aged 14 years and younger decreased from 3.4 in 2009 to 1.6 in 2010. In the last four years, the deaths were as follows: 2007 (2), 2008 (4), 2009 (4) and 2010 (2). Drawing conclusions on this data is difficult due to the small numbers.

This indicator is critical because one of the leading causes of death to children ages 1 to 14 in ND are injuries due to motor vehicle crashes. Program strategies in place to maintain and/or enhance this indicator include: ongoing public education regarding Child Passenger Safety (CPS) best practices and the ND CPS law. CPS resources are distributed statewide for parents, caregivers, agencies and others who work with caregivers of young children. The DoH facilitates over 40 statewide car seat distribution programs. The program offers car seat checkups statewide and approximately 12 cities in ND offer regularly scheduled car seat checkup clinics for the public. The DoH offers CPS trainings ranging from one hour to the 32-hour national CPS certification course for professionals such as law enforcement, public health, healthcare personnel, child care providers, social workers, Indian Health Service employees and others. The third statewide Injury Prevention and Control Conference will be held in October 2012.

The desired outcome is to reduce the number of motor vehicle deaths to children. Prevention strategies and policy and programming changes to reduce these deaths are outlined in the 2010 ND Injury Prevention Plan and are implemented through partnerships with various state wide agencies and organizations. Policy and programming changes are also addressed in the State Plan. A major section of the State Plan is dedicated to motor vehicle crashes. Data and activities relating to motor vehicle crashes can be found on pages 3-19 of the Injury Prevention plan: http://www.ndhealth.gov/injury/Publications/IPC%20Plan%20Final%202010.pdf. Additional funding is needed to increase programmatic activities and to provide additional efforts at the local level.

#03C. The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.

The source for this data is the ND Department of Health (DoH), Division of Vital Records. The death rate per 100,000 from unintentional injury due to motor vehicle crashes among youth ages 15 through 24 have decreased significantly since 2007 (25.9%). The rate for 2010 was 16.0. The denominator was based on 2010 Census data.

This indicator is critical to ND because motor vehicle crashes are the leading cause of death to youth ages 15 through 24 in ND. Drivers age 14 through 17 were involved in 7.8 percent of all crashes in 2010 but are only 3.2 percent of the total drivers in ND. The greatest percentage of unbelted crash victims were ages 20 through 24 years old. Program strategies in place to maintain and/or enhance this Indicator include assisting the ND Department of Transportation (DOT) with new projects as needed for this age group and distribution of educational materials to the public and other agencies regarding occupant protection.

The DoH collaborates with the DOT, American Automobile Association, ND Highway Patrol, Indian Health Services, tribal representatives, ND Safety Council, Safe Kids ND and the ND Injury Prevention Coalition. Through this collaboration, legislation to adopt a Graduated Driver's Licensing (GDL) system was presented during the 2011 legislative session. The bill had a large amount of support from many outside agencies and partners. While parts of the bill were adopted, there is still work to be done. Key points that were adopted include no electronic equipment use by anyone under the age of 18 years and no

night time driving past 9:00 p.m. or sunset whichever comes later unless for school, work or religious activities. Partners are planning for efforts during the 2013 legislative session to attempt to strengthen the driver's licensing system to include provisions for all novice drivers under the age of 18 years. The new additions from 2011 session included only teens ages 14 to 16 for the nighttime driving provision. The new efforts will focus on all drivers under the age of 18 years and add a passenger restriction as well as an intermediate phase for the licensing requirements. Many safety advocates are also planning to present primary seat belt legislation during the 2013 session. This will allow for easier enforcement efforts for seat belt compliance. ND currently has a texting ban for all drivers. It is hopeful that these attempts to improve the laws will reduce the number of crashes and therefore the fatalities in ND.

Our desired outcome is to reduce injuries due to motor vehicle crashes among youth aged 15 through 24 years. Prevention strategies to reduce these deaths are outlined in the 2010 ND Injury Prevention Plan and are implemented through partnerships with various state wide agencies and organizations. Policy and programming changes are also addressed in the State Plan. A major section of the State Plan is dedicated to motor vehicle crashes. Data and activities relating to motor vehicle crashes can be found on pages 3-19 of the Injury Prevention plan: http://www.ndhealth.gov/injury/Publications/IPC%20Plan%20Final%202010.pdf. Additional funding is needed to increase programmatic activities and to provide additional efforts at the local level.

#04A. The rate per 100,000 of all non-fatal injuries among children aged 14 years and younger.

The source for this data is the ND Department of Health (DoH), Division of Emergency Medical Services Trauma Registry. The rate per 100,000 of all non-fatal injuries among children ages 14 years and younger in 2006 was 141.3. The injury rates almost doubled in 2009 to 331.8. This increase was due to improvement in data collection for the Trauma Registry since 2008. The rates for 2010 increased slightly due to better reporting from smaller hospitals as well as a true increase in the actual injuries. ND has experienced an increase in population in recent years. Due to the lack of a Hospital Discharge Data System, the ND Trauma Registry is relied on for data; however, this data is limited only to cases meeting the Trauma Registry Inclusion Criteria.

This Indicator is critical because unintentional injuries are the leading cause of death to all children ages 1 through 14 in ND. Program strategies and policy and program relevant information is the same for this Indicator as in HSI #03A, #3B and #3C.

#04B. The rate per 100,000 of non-fatal injuries due to motor vehicle crashes among children aged 14 years and younger.

The source for this data is the ND Department of Transportation (DOT). The data for this indicator is for 0 through 13 years of age; not for 0 through 14 years of age. The rate per 100,000 of non-fatal injuries due to motor vehicle crashes since 2008 have increased. The trend increases from 116.4 in 2008, to 260.7 in 2009 and 262.1 in 2010. The top contributing factors to these crashes continue to be speeding, use of alcohol and driving left of the center.

This Indicator is critical because unintentional injuries are the leading cause of death to all children ages 1 through 14 in ND. Program strategies and policy and program relevant information is the same for this Indicator as in HSI #03A, #3B and #3C.

#04C. The rate per 100,000 of non-fatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.

The source for this data is the ND Department of Transportation (DOT). The rate per 100,000 of non-fatal injuries due to motor vehicle crashes (MVC) among youth ages 14 through 24 years increased slightly from 2009 to 2010. The rate for 2009 was 1,218.9 and 2010 was 1342.3. An overall look at the data shows a trend downward for injuries due to MVC since 2002.

This indicator is critical to ND because motor vehicle crashes are the leading cause of death to youth ages 15 through 24 in ND. Drivers age 14 through 17 were involved in 7.8 percent of all crashes in 2010, but are only 3.2 percent of the total drivers in ND. The greatest percentage of unbelted crash victims were ages 20 through 24 years old.

Program strategies in place to maintain and/or enhance this Indicator include assisting the ND Department of Transportation (DOT) with new projects as needed for this age group and distribution of educational materials to the public and other agencies regarding occupant protection. Additional program strategies and policy and program relevant information is the same for this Indicator as in HSI #03A, #3B and #3C.

#05A. The rate per 1,000 women aged 15 through 19 years with a reported case of Chlamydia.

The rates per 1,000 women ages 15 through 19 years with a reported case of Chlamydia has varied over the last five years from a low of 13.6 in 2005 to high of 21.7 in 2009. The 2010 rate was 20.9. Increased awareness and Get Yourself Tested (GYT) campaigns may account for the increase, as more individuals are getting tested.

This indicator is critical to ND due to the serious complications that can occur due to Chlamydia and other sexually transmitted diseases (STD). Both Chlamydia and gonorrhea can cause pelvic inflammatory disease (PID). Women who have had PID may not be able get pregnant or have children. Women infected with a variety of STDs such as gonorrhea, Chlamydia, herpes, hepatitis B, and syphilis can pass these infections onto their babies. All of the infections can be given to the baby when the baby passes through the birth canal of an infected mom.

Babies infected with STDs are at risk for a variety of health problems. Babies infected with syphilis while still in the womb may die; have deformed bones, brain damage and other problems. Babies infected with herpes at birth may develop encephalitis, a swelling in the brain that may cause permanent brain damage or death. Babies infected with hepatitis B will likely have hepatitis the rest of their lives and may develop liver failure and die. Babies infected with Chlamydia or gonorrhea usually have eye infections. Babies can also develop pneumonia from Chlamydia.

Complications in men can also occur. Chlamydia and gonorrhea can cause epididymitis which is an infection of a structure attached to the testicles. This infection can lead to infertility on rare occasions.

Program strategies in place to maintain and/or enhance this Indicator include STD testing available through local public health and Family Planning programs to this age group without parental consent and declaration of a nationwide STD awareness month for April of every year.

The Family Planning Program has implemented rapid HIV testing, which provides test

results in twenty minutes. This has increased HIV awareness and the number of adolescents and adults who know their HIV status.

#05B. The rate per 1,000 women aged 20 through 44 years with a reported case of Chlamydia.

The rates per 1,000 women ages 20 through 44 with a reported case of Chlamydia have varied over the last five years from a low of 6.6 in 2005 to a high of 11.8 in 2007. The 2010 rate was 10.1 Increased awareness and Get Yourself Tested (GYT) campaigns may account for the increase, as more individuals are getting tested. The 2010 Chlamydia incidence rate for ages 15 through 19 years is much higher (20.9 compared to 10.1). This could indicate that this older age group is better prepared for sexual activity.

Program strategies and policy and program relevant information is the same for this Indicator as in HSI #05A.

#06A & B. Infants and children aged 0 through 24 years enumerated by sub-populations of age group, race and ethnicity.

The source for this data is the U.S. Census Bureau and the U.S. Bureau of Labor Statistics, 2010 decennial census data. Minimal change occurred over the last 10 years in the number of children, youth, and young adults in ND. In 2000, the total population 0 through 24 years was 233,967 compared to 230,891 in 2010. ND remains predominately white with American Indians the largest minority population. There has been a decrease in the American Indian population when comparing 2009 population estimates to the actual 2010 census. In addition, ND has a small Hispanic population, which increased slightly from 2009 to 2010. The 2010 decennial census data indicates that there is a slight increase in more than one race reported. Although racial minorities in ND continue to represent a relatively small proportion of the state's total population, their numbers have increased slightly in 2010 compared to 2009.

This indicator is critical as infants and children compromise a large portion of the population in ND. Approximately 34 percent of the ND population is between the ages of zero and 24 years. Promoting healthy behaviors at an early age is important to decrease morbidity and mortality as the population ages. In an effort to target appropriate populations, Title V programs review data to assist with program planning and implementation. The programs provide technical assistance, education and access to resources to those populations in greatest need.

By identifying current data and monitoring trends, this allows ND to develop and modify programs in order to meet our state specific needs. ND's largest minority population is American Indian. Thus, Title V programs focus on delivering education and outreach that is culturally appropriate for the tribal areas in our state. In addition, the increasing racial minorities and changes in ND sub-populations may require modifications to programs to improve their effectiveness. One of ND's state priorities/performance measures relates specifically to forming and strengthening partnerships with American Indians and underrepresented populations: http://www.ndhealth.gov/familyhealth/FactSheets/SPM1Partnerships.pdf.

#07A & B. Live births to women (of all ages) enumerated by maternal age, race and ethnicity.

The source for this data is the ND Department of Health (DoH), Division of Vital Records.

Live resident births to women of all ages increased from 8,974 in 2009 to 9,088 in 2010. ND remains predominately white, with American Indian the largest minority population and a very small Hispanic population. In 2010, 83.7 percent of live births were to white women, while 9.8 percent of live births were to American Indian women. 1.9 percent of the births were to women 17 or younger, 9.5 percent were to women age 35 and older, and 83.1 percent of births were for women ages 20 through 34. Births to women 17 or younger were higher in American Indian women at 6.3 percent compared to 1.3 percent among white women 17 or younger.

The Family Planning Program has meetings planned for summer 2012 with the Turtle Mountain Reservation to discuss teen pregnancy prevention initiatives. Additional program strategies and policy and program relevant information is the same as HSI's #01A and #06A & B.

#08A & B. Deaths to infants and children aged 0 through 24 years enumerated by age subgroup, race and ethnicity.

The source for this data is the ND Department of Health (DoH), Division of Vital Records. Deaths of infants and children 0 through 24 years of age have decreased from 160 infants and children in 2009 to 155 in 2010. American Indian's have a higher rate of deaths in proportion to the population. For children zero through age 24, the leading causes of death are injuries, suicide, Sudden Infant Death Syndrome (SIDS), cancer, diseases of the heart and homicide.

Over 38 percent of deaths occurred in the first year of life. Of those infants that died in the first year of life, 25.4 percent were American Indian. The rate of SIDS for the American Indian population remains higher than the white population at 3.4 deaths per 1,000 births compared to 0.3 deaths per 1,000 births among whites in 2010.

Nearly half of all deaths occurred for children ages 15 through 24 (50.3%). From 2006 through 2010, the motor vehicle crash death rate among American Indians ages 15 through 18 was four times higher than whites. Young adults ages 20 through 24 accounted for 27.0 percent of the deaths. The suicide rate among American Indians ages 19 through 24 was nearly five times higher than whites from 2006 through 2010.

The DoH is a member of the Child Fatality Review Panel which reviews all deaths for children under the age of 18. Following review of these deaths, a report is compiled and recommendations are made to legislators, law enforcement, coroners and other pertinent parties for improvement of outcomes for children in the identified age group.

Program strategies and policy and program relevant information is the same as HSI's #03A, #03B and #03C.

#09A & B. Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race and ethnicity.

The source for this data is the U.S. Census Bureau and various programs located in the ND Department of Human Services Medicaid, Temporary Assistance for Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP), Children's Health Insurance Program (CHIP), and Foster Care; the ND Department of Health Women, Infants and Children Program (WIC); the ND Department of Public Instruction (high school drop-out rates); and, the ND Bureau of Criminal Investigation (juvenile crime).

Generally, infants and children ages zero through 19 years have decreased since 2000,

while the percentage of single parents has increased. Over the years, fluctuations are apparent in many of the identified program categories. Between 2009 and 2010, increases have been noted in Medicaid, CHIP, SNAP, and juvenile crime rates. Slight decreases have occurred in TANF, WIC, high school drop outs, and Foster Care. For many programs, ethnicity is not reported.

Title V staff and programs continually support referral to State programs that provide resources to ND families.

#10. Geographic living area for all resident children aged 0 through 19 years.

In terms of overall population, there was an increase statewide during the 2010 decennial census, but a decrease of children from birth through age 19. According to the U.S. Census Bureau's 2010 redistricting data, the current population in ND is 672,591, which is the second highest population in the state's history and a five percent increase from the 642,200 persons in the 2000 decennial census. The age distribution of ND's population has changed considerably over the last several decades. In the 1940's, children ages 0 to 17 comprised 36 percent of ND's total population. This proportion decreased to 22 percent in 2010. In the 2000 decennial census, there were 183,464 children birth through 19 years of age in ND compared to 171,935 children in the 2010 decennial census. Nationally, the number of children grew 1.6 percent.

The population in ND continues to be concentrated, with the majority of North Dakotans (53 percent in 2010) residing in the top four populated counties (Cass, Burleigh, Grand Forks and Ward). This is up from 49 percent in 2000. In ND, 11 counties grew in population from 2000 to 2010. These counties consisted of metropolitan counties, reservation counties, and a handful of western oil producing counties. From 2000 to 2010, Cass County had the largest percentage growth (22 percent) followed by Burleigh and Mountrail counties at 17 percent and 16 percent respectively. Towner and Sheridan counties had the largest percentage decreases in the state, each losing approximately 22 percent of their population from 2000 to 2010. Among all of the states in 2010, ND ranked 48th in total population and had the 37th largest population growth rate from 2000 to 2010.

During 2009 and 2010, ND continued to experience in-migration in the western part of the state. In 2009, the state experienced a net international in-migration of 521 people. Population projections released by the ND State Data Center indicate the state's population is expected to grow over the next twenty years.

Leading trends influencing the state's future population which are used to project future county populations within ND are: 1) rural depopulation, 2) out-migration of young adults and young families, 3) an increasing proportion of elderly, and 4) in-migration due to heightened energy development activity in western ND. Decades of movement of rural residents to the larger cities have depopulated much of rural ND. Currently, more than half of the 53 counties in the state have a population base below 5,000 residents. In the last decade, population growth occurred largely in the metropolitan and American Indian reservation counties of the state. The loss of residents in their twenties and early thirties has increased markedly over the past two decades. The loss of young adults means that there will be fewer parents of childbearing age and therefore fewer children. If current trends continue, the number of elderly in the state will grow by 58 percent over the next 20 years and represent nearly 23 percent of the state's population.

Examining this is data is critical in planning and implementing Title V services and programs.

#11. Percent of the State population at various levels of the federal poverty level.

The source for this data is the U.S. Census Bureau and the U.S. Bureau of Labor Statistics, Current Population Survey, March supplements. In 2010, fewer ND residents met the three monitored Federal Poverty Levels (FPL). Overall, the percent of ND's population at lower ends of the federal poverty levels has decreased from 2009 to 2010. The number of residents below 50 percent of the FPL decreased from 5.4 percent in 2009 to 4.4 percent in 2010. When looking at 100 percent of the FPL, 12 percent of residents met the criteria in 2009 compared to 11 percent in 2010. For 200 percent of the FPL, 29.7 percent of residents met the criteria in 2009 compared to 27.3 percent in 2010.

The effect of poverty on health has been clearly documented, thus understanding poverty in ND can lead to prevention efforts to improve health outcomes. Program strategies and policy and program relevant information can be found in Part Two, Section IV., National Performance Measures #4 and #13.

#12. Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.

The source for this data is the U.S. Census Bureau and the U.S. Bureau of Labor Statistics, Current Population Survey, March supplements. In 2010, fewer ND children age zero to 19 years met the three monitored Federal Poverty Levels (FPL). Overall, the percent of ND's child population at lower ends of the federal poverty levels has decreased from 2009 to 2010. The number of children below 50 percent of the FPL decreased from 10 percent to 6.3 percent in 2010. When looking at 100 percent of the FPL, 18.5 percent of children met the criteria in 2009 compared to 14.7 percent in 2010. For 200 percent of the FPL, 38.2 percent of children met the criteria in 2009 compared to 33.3 percent in 2010.

The effect of poverty on health has been clearly documented, thus understanding poverty in ND can lead to prevention efforts to improve health outcomes. Program strategies and policy and program relevant information can be found in Part Two, Section IV., National Performance Measures #4 and #13.//2013//

F. Other Program Activities

The Domestic Violence/Rape Crisis Program provides grants to domestic violence/rape crisis, law enforcement, courts and prosecutorial agencies to reduce and prevent violence against women.

The Family Violence Prevention and Services Program assists in establishing, maintaining, and expanding programs and projects to prevent family violence and to provide immediate shelter and related assistance for victims of family violence and their dependents. Grant funds are distributed on a formula basis to 17 of 21 domestic violence/rape crisis agencies and to the state domestic violence coalition. Uses for the funds include: 24-hour crisis lines, emergency and long term shelter, crisis intervention, counseling for children who are victims of or witness domestic violence, peer support and counseling, court advocacy, child visitation centers, public education, and training community professionals.

Domestic Violence State General Funds provide funding to all 21 domestic violence/rape crisis agencies in ND. Grant funds are distributed on a formula basis that factors in service area population, clients served, and services offered. Uses for the funds include: 24-hour crisis line, protection order assistance, statewide data collection, adult and child support group, emergency shelter, child advocacy services, community education, primary prevention, coordinated community response, domestic violence offender treatment, and supervised visitation and exchange services.

Rape Crisis grant funds provides services to victims of sexual assault. These funds are distributed on an equal basis to 17 of the 19 domestic violence/rape crisis agencies to manage crisis lines and provide services to victims of sexual assault.
/2012/ These funds are distributed on an equal basis to 16 of the 21 domestic violence/rape crisis agencies.//2012//
/2013/ These funds are combined with the Rape Prevention and Education funds to support primary prevention of sexual violence.//2013//

Rape Prevention and Education grant funds are used to educate communities about sexual assault and to develop programs to prevent it. These funds are distributed on a formula basis to 19 domestic violence/rape crisis agencies to support educational seminars, crisis hotlines, training programs for professionals, development of informational materials, and special programs for underserved communities. The state domestic violence/sexual assault coalition also receives funds to implement prevention projects for middle schools and campuses on a statewide basis.
/2012/ Sexual Violence Prevention Grant (RPE) funds are used to implement strategies using evidence supported programs for the primary prevention of sexual violence. These funds are distributed to eight domestic violence/rape crisis agencies that are implementing prevention strategies directed to target populations. The state domestic violence/sexual assault coalition also receives funds to provide technical assistance and training on primary prevention as well as coordinate a state team to implement the state plan.//2012//

Due to new federal grant guidelines, only three visitation centers were able to receive funding from the 2008 -10 Safe Havens grant. In 2011, the ND Department of Health (DoH) received $425,000 in State General Funds to support the seven visitation centers in ND. These funds are distributed based on a formula that factors in number of visitation and exchange hours. Safe Havens-State General Funds are used to help create safe, secure and respectful environment for visitation with and exchange of children in cases of domestic violence, child abuse, sexual assault, or stalking. A supervised visitation/exchange center must meet the minimum requirements set forth in the Standards for Supervised Parenting Time and Exchange Centers in ND to receive the general funds. Seven local visitation centers receive funds to build an infrastructure of a statewide network of providers and enhance and strengthen local services to families. The DoH does not contract with ND Department of Human Services to manage the general funds, but directly contracts with the seven visitation centers.

Grants to Encourage Arrest Policies and Enforcement of Protection Orders Program recognizes domestic violence as a crime that requires the criminal justice system to hold offenders accountable for their actions through investigation, arrest, and prosecution. The ND Council on Abused Women's Services (CAWS) has been contracted to oversee management of the project. CAWS will collaborate with Minot State University's Rural Crime and Justice Center and the Northern Plains Tribal Judicial Training Institute, and a multidisciplinary advisory team from local law enforcement, domestic violence/rape crisis, tribal and prosecution agencies to assist in implementing the grant goals. The grant goals are to develop a model law enforcement domestic violence policy for ND, develop a train-the-trainer curriculum on local policy development, and create a pool of officers to serve as technical assistance and training resources for local law enforcement agencies and community response teams.

The STOP Violence Against Women formula grants program encourages the development and strengthening of effective law enforcement and prosecution strategies to address violent crimes against women and the development and strengthening of victims' services in cases involving violent crimes against women. Funds are allocated to 19 domestic violence/rape crisis agencies.
/2012/ Funds are allocated to 21 domestic violence/rape crisis agencies.//2012//
/2013/ Additional agencies funded include law enforcement, prosecution, courts, hospitals and other agencies.//2013//

Since 2005, the Sexual Violence Prevention Grant and the Enhancing and Making Programs and

Outcomes Work to End Rape grants have been utilized to assist domestic violence/rape crisis agencies implement and evaluate primary prevention strategies. Currently, eight agencies and the CAWS are funded.

The Grants to Encourage Arrest Policies and Enforcement of Protection Orders Program grant is focusing on updating the model law enforcement domestic violence policies; developing a "Best Practices" procedural manual for removal of firearms in protection orders and in misdemeanor domestic violence convictions; present information on domestic violence and sexual assault dynamics to state and tribal court judges in addition to providing information on how better to handle these cases in court; develop a model policy for ND law enforcement response to sexual assault; develop and distribute a brochure describing the signs and symptoms of strangulation, investigative techniques, and ND's new strangulation law; provide legal assistance to victims seeking to access the protection order process; and develop safety and accountability audit teams in two communities to analyze and make recommendations to improve dispatch, law enforcement and domestic violence advocacy response to victims of domestic violence, and in two other communities to analyze and make recommendations to improve prosecution, judiciary and probation response to victims of domestic violence.
/2012/ The 2008 -- 2010 Grants to Encourage Arrest Policies and Enforcement of Protection Orders Program grant will complete a one-year no-cost extension August 31, 2011. The DoH was not awarded the 2010-2012 grant, but has applied for the 2011-2013 grant.//2012//
/2013/ Received in 2011, the DoH contracted with Minot State University's Rural Crime and Justice Center to provide training to address domestic violence in oil country.//2013//

ND received $812,159 in Recovery Act STOP funds to be used to create and preserve jobs and promote economic growth while improving responses to domestic violence, dating violence, sexual assault and stalking. 34 agencies were awarded funds.
/2012/ This grant was completed as of April 30, 2011.//2012//

G. Technical Assistance

The major issues that ND has identified to receive technical assistance includes the following:

1) Capacity Assessment: The five-year needs assessment process provided a broad picture of health system capacity. The core public health functions and MCH essential services describe program activities and roles within the context of the larger health care environment. The effects of Title V activities/program and population outcomes are measured in part by the Title V Performance Measures, Health System Capacity Indicators and Health Status Indicators, along with other state and national outcomes. A Capacity Assessment conceptually links program's roles and activities to population health and service systems through a strategic assessment of organization capacity needs. Through a Capacity Assessment, ND's Title V programs hope to determine what organizational, programmatic and management resources must be developed or enhanced in order to fulfill the program's goals and objectives. Expertise required to complete a comprehensive Capacity Assessment is not readily available in the state.

2) Health Equity, Social Determinants and Life Course Perspective: Incorporating these new concepts will include changes in health care practices, policies and strategies. These developing concepts require increased knowledge and expertise to successfully integrate into MCH practice.

For these two identified needs, expertise is not readily available in the state.

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2011		FY 2012		FY 2013	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	1818028	1061747	1803901		1815867	
2. Unobligated Balance *(Line2, Form 2)*	596783	596783	606009		601300	
3. State Funds *(Line3, Form 2)*	1673358	1782307	1777433		1791875	
4. Local MCH Funds *(Line4, Form 2)*	137750	45685	30000		21000	
5. Other Funds *(Line5, Form 2)*	0	0	0		0	
6. Program Income *(Line6, Form 2)*	0	0	0		0	
7. Subtotal	4225919	3486522	4217343		4230042	
8. Other Federal Funds *(Line10, Form 2)*	2583000	2249823	2215000		2034506	
9. Total *(Line11, Form 2)*	6808919	5736345	6432343		6264548	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2011		FY 2012		FY 2013	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	604646	303034	430347		414220	
b. Infants < 1 year old	906969	695573	1004142		955109	
c. Children 1 to 22 years old	1187697	959534	1221972		1343012	
d. Children with	1323206	1316733	1320687		1318749	

Special Healthcare Needs						
e. Others	112500	115125	150000		90000	
f. Administration	90901	96523	90195		108952	
g. SUBTOTAL	4225919	3486522	4217343		4230042	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	100000		100000		100000	
c. CISS	0		0		0	
d. Abstinence Education	89000		0		0	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	0		0		0	
h. AIDS	0		0		0	
i. CDC	305000		305000		362561	
j. Education	0		0		0	
k. Home Visiting	0		0		0	
k. Other						
ECCS	140000		140000		150000	
Family Planning	1115000		1178000		1161900	
HRSA Oral Health	0		258000		260045	
BRFSS	250000		234000		0	
Home Visiting	584000		0		0	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2011		**FY 2012**		**FY 2013**	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	857017	871479	821538		998290	
II. Enabling Services	461470	500500	389683		472073	
III. Population-Based Services	1477381	749505	1231464		1033822	
IV. Infrastructure Building Services	1430051	1365038	1774658		1725857	
V. Federal-State Title V Block Grant Partnership Total	4225919	3486522	4217343		4230042	

A. Expenditures

Please refer to the attached document.

An attachment is included in this section. VA - Expenditures

B. Budget

Please refer to the attached document.

An attachment is included in this section. VB - Budget

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.